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ABSTRACT

Results of evaluating U.S. exchange programs for foreign medical graduates (FMGs) are presented. After reviewing the roles of sponsors of exchange visitor programs and identifying specific sponsors, attention is directed to entry patterns of exchange visitor physicians, and the value of these programs to both home countries and the United States. Findings are reported separately for 14 issues, and the value of exchange programs for 20 countries is discussed. Findings show: there are over 230 public and private sponsoring organizations; in any given year since 1979, there were about 4,500 physician exchange visitors present in the United States, of which about 2,500 were new entrants; and the total number of FMGs in graduate medical education positions has remained at 12,000 to 13,000 per year from 1977-1978 to 1981-1982. Information is also provided on countries of origin of immigrant physicians and exchange visitor FMGs, and the return home of exchange visitor FMGs. Additional contents include information on the benefits of participation for specific FMGs, recommendations regarding exchange programs, a chronological listing of relevant legislation, a bibliography, and a revision of a report by Thomas D. Dublin entitled "The Changing Role of the Foreign Medical Graduate in the Practice of Medicine in the U.S." (SW)

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REPORT TO CONGRESS ON PHYSICIAN EXCHANGE VISITOR PROGRAMS

May 1983

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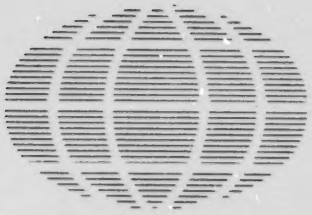
REPORT TO CONGRESS ON PHYSICIAN EXCHANGE VISITOR PROGRAMS



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U.S. DEPARTMENT OF
HEALTH & HUMAN SERVICES
Public Health Service
Health Resources and Services Administration
Bureau of Health Professions
Division of Medicine

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PURPOSE

Section 5(e) of Public Law 97-116, the Immigration and Nationality Act Amendments of 1981, requires the Secretary, Department of Health and Human Services (DHHS), to "evaluate the effectiveness and value to foreign nations and to the United States of exchange programs for the graduate medical education or training of aliens who are graduates of foreign medical schools." A report on this evaluation is due to the Congress not later than January 15, 1983.

In its deliberations on the bill that became Public Law 97-116, the House Judiciary Committee stated that it was hopeful that future policymaking by the Executive Branch would be based on an assessment of the actual impacts that the exchange programs for graduate medical education or training have had on improving medical care delivery in foreign countries and on enhancement of the United States' foreign policy objectives.

Although P.L. 97-116 assigns lead responsibility for implementation of the provision to the Secretary, DHHS, the Exchange Visitor Program is administered by the United States Information Agency (USIA). Thus, staff members of the Department have worked closely with USIA, in the collation of relevant data for preparation of the final report.

This Report to Congress offers a significant opportunity for review and possible changes in U.S. exchange programs for foreign medical graduates (FMGs) since the statute specifies the inclusion of "such recommendations for changes in legislation and regulations as may be appropriate."

The organization of this Report consists of initial background regarding the roles of sponsors of exchange visitor programs and progresses through findings on entry patterns of exchange visitor physicians, the value of these programs to home countries, and finally their value to the United States.

ACKNOWLEDGEMENTS

This Report was prepared by Daniel N. Masica, M.D., Ms. Magdalena Miranda, Mrs. Brenda E. Selser, and Mr. Mint Basnight, Jr., of the Health Resources and Services Administration (HRSA), Robert Graham, M.D., Administrator; the Bureau of Health Professions, Thomas D. Hatch, Director; and the Division of Medicine, Kenneth P. Moritsugu, M.D., M.P.H., Director.

We would like to express our appreciation to: Staff and officers of the Educational Commission for Foreign Medical Graduates, especially Mrs. Marie L. Shafron, Ray L. Casterline, M.D., and Samuel P. Asper, M.D.; staff of the Fogarty International Center, especially Mark S. Beaubien, M.D. and Ms. Wanda J. Pifer; Mr. James E. Mahoney, Deputy Associate Administrator for International Health Affairs, HRSA; Joseph P. Evans, M.D., Consultant to the American College of Surgeons; Ms. Marvelle B. Toney, of the Pan American Health Organization; staff and faculty of the Johns Hopkins University, School of Hygiene and Public Health, especially Timothy D. Baker, M.D. and Edyth H. Schoenrich, M.D.; and staff of the United States Information Agency, especially Mr. Edward A. Silvis, Mr. James W. Kelman, Ms. Vivian Smith and Ms. Pamela Vanderbilt, along with staff of overseas posts, for their contributions and assistance in the preparation of this report.

Special recognition is given to Ms. Deidra R. Allen, Ms. Eve A. Morrow, and Ms. Cynthia E. Brady for their assistance and perseverance in the preparation of the tabular data and typing of the Report.

EXECUTIVE SUMMARY

REPORT TO CONGRESS ON PHYSICIAN
EXCHANGE VISITOR PROGRAMS

PURPOSE OF REPORT

Section 5(e) of Public Law 97-116, the Immigration and Nationality Act Amendments of 1981, requires the Secretary, Department of Health and Human Services (DHHS), to "evaluate the effectiveness and value to foreign nations and to the United States of exchange programs for the graduate medical education or training of aliens who are graduates of foreign medical schools."

This Report to Congress offers a significant opportunity for review and possible changes in U.S. physician exchange programs since the statute requiring submission of this Report specifies the inclusion of "such recommendations for changes in legislation and regulations as may be appropriate."

BACKGROUND

Over the past four decades, international exchange programs between the United States and other nations have constituted an important foreign policy undertaking. The purpose of such programs is to improve and strengthen the international relations of the United States by enhancing mutual understanding through educational and cultural exchange. These exchanges involve the movement of persons between countries for the purpose of sharing knowledge, skills, ideas, and culture.

Exchange visitors, by definition, are nonimmigrants entering the United States under J-visa status for the purpose of educational or cultural exchange. There are at least 25 Federal Government Departments and Agencies operating international exchange or training programs which sponsor J-visa exchange visitors. In addition, there are approximately 1,380 programs sponsored by national, state or local government agencies, educational institutions such as schools, colleges, universities, seminaries, libraries, museums, institutions devoted to scientific and technological research, hospitals and related institutions, nonprofit associations, foundations, institutes, and business and industrial concerns.

Major changes which impact on exchange visitor physicians were implemented six years ago with the passage of the Health Professions Educational Assistance Act of 1976 (Public Law 94-484). These changes relate to examination requirements, limitation on length of stay in the U.S. and a requirement that

exchange visitor physicians who enter the country for graduate medical education return to their home country or last permanent residence for two years after completion of training before a change of status to an immigrant category or another type visa can be considered.

While there are many sponsors of exchange visitor physicians, the Educational Commission for Foreign Medical Graduates (ECFMG) has a special role in regard to alien foreign medical graduates (FMGs). The Educational Commission for Foreign Medical Graduates is authorized by the United States Information Agency (USIA) to provide sponsorship for alien FMGs who wish to participate in accredited graduate medical education or clinical fellowship training in the United States.

TIMELINESS OF REPORT

There is current concern regarding the adequacy of the projected future number of accredited graduate medical education (GME) training positions to accommodate the expanded number of graduates from U.S. medical schools. This underscores the urgency of reviewing GME opportunities for exchange visitor physicians.

METHODOLOGY

The Department has worked very closely with the United States Information Agency in collating, organizing and analyzing available data on foreign medical graduate (FMG) exchange visitors. Available literature on the effectiveness and value of physician exchange visitor programs to the U.S. and the home country has also been reviewed.

Sources of data included the Educational Commission for Foreign Medical Graduates, the United States Information Agency, the Pan American Health Organization, the National Institutes of Health, the Centers for Disease Control, and the Johns Hopkins University, School of Hygiene and Public Health.

The Educational Commission for Foreign Medical Graduates provided information on the total number of ECFMG-sponsored exchange visitors, as well as the number of ECFMG-sponsored new entrants by country that have participated in graduate medical education in the U.S. over the last decade.

The United States Information Agency provided information on the total number of FMG exchange visitors, the total number of sponsors of FMGs and the total number (new entrants and continuations) of FMGs participating in training programs other than graduate medical education.

In addition, USIA polled over 30 overseas posts requesting information on the number of FMGs participating in U.S. training programs, the number returning home, and documentation of the value to the home country of the training received in the U.S.

FINDINGS

With few exceptions, systematic and comprehensive studies on the effectiveness and value of physician exchange visitor programs to foreign nations and to the United States are lacking. While there is extensive literature on the topic of foreign medical graduates, prior studies have focused, for the most part, upon the impact on the U.S. supply of physicians and the roles of FMGs in the U.S. health care system.

In many cases, from existing information, one can only indirectly assess the value of such programs to foreign nations. However, this report represents an essential first step in addressing this complex topic.

In assembling the information for this report, it was apparent that widespread misperceptions exist regarding exchange visitor programs for FMGs. These misperceptions stem in part from analysis of data from the 1970's which often did not distingush among different categories of foreign medical graduates who entered the U.S. for temporary study or immigration. In addition, such misperceptions can partially be attributed to the prevalent tendency to overlook the underlying purpose of exchange visitor programs, i.e. to improve and strengthen the international relations of the United States by enhancing mutual understanding through educational and cultural exchanges. Exchange programs by necessity must involve the movement of persons between countries for the purpose of sharing knowledges, skills, ideas and culture.

The following represent major findings regarding exchange visitor programs for FMGs. Other findings and supporting documentation and data are found in the full text and appendices of this report.

Characteristics of Exchange Visitor Programs for Foreign Medical Graduates

There are over 230 sponsoring organizations for exchange programs for FMGs representing a wide variety of organizations from the public and private sectors.

While ECFMG is the leading sponsor for exchange visitor physicians in graduate medical education (GME), there are large numbers of exchange visitor physicians (sponsored by other institutions) who are participating in research, observation, consultation and teaching. Among these institutions are the Pan American Health Organization, prestigious universities and medical centers nationwide, the National Institutes of Health, and the Agency for International Development.

In any given year since 1979, approximately 4,500 of the 70,000 to 80,000 exchange visitors present in the U.S. were physicians. Of the physicians (4,500), an estimated 2,500 have been new entrants.

Exchange Visitor FMGs in Graduate Medical Education

In the early 1970's, several thousand exchange visitor physicians annually came to the U.S. to pursue graduate medical education, i.e. residency training. The number of exchange visitor physicians in GME has fallen dramatically since that time. (See Attachment 1, p. xix.)

Since 1979, approximately 400-600 exchange visitor physicians per year have entered residency training. In academic year 1981-82, only 544 physicians were sponsored by ECFMG as new entrant exchange visitors. This is in sharp contrast to 2,917 new entrants in academic year 1973-74.

Currently only 20 percent (494) of new entrant exchange visitor FMGs (2,500) are entering the country to participate in graduate medical education or training.

The number of new entrant exchange visitor FMGs in academic year 1981-82 in accredited GME programs represented only two (2) percent of the total number of all postgraduate year one (PGY-1) residents.

In academic year 1978-79, the number of new entrant exchange visitor physicians entering accredited GME was only 296, the lowest number in a decade. This was the first year that a new examination, the Visa Qualifying Examination (VQE), was required for new entrants and limitations placed on individual length of stay.

In addition to the reduction in the number of new entrant exchange visitor physicians entering GME, there has been a significant reduction in the number of countries participating in ECFMG-sponsored graduate medical education over the past 10 years. In academic year 1972-73, 109 countries sent exchange visitors while in academic year 1981-82 only 66 countries were represented in new entrants sponsored by ECFMG.

Non-Exchange Visitor FMGs in Graduate Medical Education

While the number of exchange visitor physicians in GME has decreased dramatically, the total number of FMGs in GME positions has remained at 12,000 to 13,000 per year over the last 5 academic years, 1977-78 to 1981-82.

This plateau has occurred owing to the continuing entry of immigrant FMGs as well as the increased number of returning U.S.-citizen FMGs.

In academic year 1981-82, the number of U.S.-citizen FMGs in total accredited GME positions was 5,778 in contrast to 1,552 exchange visitor FMGs and 5,863 alien physicians who were not sponsored exchange visitors.

Over the last 3 years the number of alien physicians in GME who are not exchange visitors has remained over 5,000.

Alien FMG Entry into the United States

Immigration data reflects differences in the entry pattern of physicians into the country. Larger differences between the number of physicians entering as immigrants and those entering as exchange visitors is shown to have occurred over the past several years. For the latest fiscal year for which data for comparison are available, i.e., 1979, there were 7 times as many immigrant physician entrants (3,040) as exchange visitor physicians (420).

Comparison of Countries of Origin of Immigrant Physicians and Exchange Visitor FMGs

In 1976, the 10 leading countries contributing immigrant physicians to the U.S. exceeded (often by many fold) the number of new entrant exchange visitors entering GME from that country and in FY 1978, the number of immigrant physicians admitted from just two countries (India and the Philippines) was larger than the total number of new entrant exchange visitors from all 81 countries.

Countries of Origin of Exchange Visitor FMGs

In contrasting academic years 1973-74 to 1976-77 with academic years 1978-79 to 1981-82, all but one of the 30 leading countries (Canada), showed significant decreases in numbers of new entrants. For 18 of these 30 countries, the decrease was greater than 80 percent. The remaining 11 countries demonstrated decreases ranging from 38 percent to 79 percent.

The individual country decreases between the two periods (academic years 1973-74 to 1976-77 and academic years 1978-79 to 1981-82) were often striking. The number of new entrants from India decreased by 91 percent from 949 to only 82; Iran, by 98 percent, from 507 to 10; China (Taiwan) by 91 percent, from 404 to 37; and the Philippines, by 83 percent, from 903 to 152.

Examples of other countries which showed a striking decrease in the number of new entrants include: Thailand, from 243 to 23; Mexico, from 224 to 23; and Colombia, from 106 to only 5.

Wide intercountry variations exist in entry patterns of ECFMG-sponsored FMGs. For the 9-year interval of academic years 1973-74 to 1981-82 approximately 40 percent of all new entrant FMGs came from five countries, i.e. Canada, the Philippines, India, Iran and China (Taiwan). An additional ten countries accounted for the next 26 percent of new entrants and approximately one hundred for the remaining 34 percent.

Return Home of Exchange Visitor FMGs

Specific data on the number of or the rate of return of exchange visitor physicians is not generally available.

In assessing return home rates, it is important to differentiate among the various types of exchange visitor physician programs.

Residency programs can have an impressive track record in terms of the ratio of returning home exchange visitor FMGs, if emphasis is given to this factor.

There is some evidence that the vast majority of exchange visitor FMGs receiving training in public health have returned to work in their home countries.

For exchange visitor physicians in the area of medical research for one specific program (i.e., the NIH International Research Fellowship Program), there is evidence that a majority return home and assume roles for which they have been trained.

Value to Home Countries

For many nations, not only have substantial numbers of exchange visitor physicians returned to their home country, but more importantly they are received favorably and have contributed significantly to improvement of the health care system in their homelands.

In many cases, from existing information, one can only indirectly assess the value of physician exchange programs to foreign nations. Nonetheless, it can be noted that major contributions to home countries have been made in areas of public health and medical research, as well as in clinical medicine and surgery. Furthermore, exchange visitor programs for FMGs have contributed to enhanced medical sciences on an international scale.

Given the specific return-home legislative provisions contained in the Health Professions Educational Assistance Act of 1976 (P.L. 94-484) and subsequent amendments, it can be anticipated that the majority of exchange visitor FMGs currently in GME will return to their home countries.

Value to the United States

Benefits to the United States from exchange visitor programs for FMGs have included: enhancement of international relations; timely acquisition of information on advances from around the world in areas of clinical medicine, public health and medical research; and the fostering of attitudes worldwide that a democratic government is vitally interested in the health and advancement of peoples of all nations.

In addition to these primary benefits, many exchange visitor FMGs upon returning home assume leadership roles in health fields at the local and national level and afford excellent opportunities for interested U.S. health industries to pursue international commercial activities and thereby benefit the American economy.

CONCLUSIONS

Over the decade 1972-82, exchange visitor FMGs have come to the U.S. on temporary visa status from over 120 countries worldwide.

Data in this Report underscore the impression that misperceptions regarding exchange visitor FMGs stem in large part from reliance on FMG data from the early 1970's. Patterns of entry of exchange visitor FMGs are markedly different than a decade ago.

Physician exchange visitor programs have been and continue to be of value to the U.S. as well as to home countries.

If opportunities for exchange visitor FMGs to pursue GME in the United States continue to diminish, it will not only tarnish our image abroad, but ironically may force FMGs to seek immigrant status to the U.S. in order to pursue medical career goals.

Finally, it must be recognized that nations with ideologies far different than that of the U.S. are aggressively pursuing medical education exchanges around the world, especially with developing countries.

RECOMMENDATIONS

This Report to Congress offers a significant opportunity for review and possible changes in U.S. physician exchange programs since the statute requiring submission of this report (Section 5(e) of P.L. 97-116) specifies the inclusion of "such recommendations for changes in legislation and regulations as may be appropriate."

As documented in this Report, there are complex, interwoven issues which must be considered in any discussion of physician exchange visitor programs.

This section on recommendations is divided into three components: 1) underlying assumptions; 2) principles/overall strategies; and finally 3) recommendations.

Underlying Assumptions for Development of Recommendations:

- There will continue to be a diversity of physician exchange visitor programs with varied specific objectives (e.g., graduate medical education, medical research, public health, etc.)

- Government Agencies (e.g., USIA, DHHS) interested in physician exchange visitor programs will continue operations with

steady-state or diminishing resource levels, including staff as well as operating budget and extramural program funds.

- It is impossible to develop statutory language and regulations which cover every specific situation involving physician exchange visitors. Some flexibility in approach must be maintained to deal with extraordinary circumstances which arise periodically.

- Entry into accredited residency training positions will be increasingly competitive owing to the expansion in the number of graduates of U.S. medical schools along with other factors.

Principles/Overall Strategies in Developing Recommendations:

- International exchange programs continue to be an important policy undertaking by the United States.

- Neither Congress, the Administration nor the American medical profession would be supportive of approaches to enhance physician exchange program which did not foster as a prime objective the return home of participating FMGs.

- Any approach must take into consideration the wide range of medical education and health care delivery needs of the foreign nations repesented by exchange visitor physicians.

- Given the complicated interwoven issues surrounding physician exchange visitor programs, there is no single, simple recommendation which can address these. There is the need for a set of recommendations to address the set of issues.

- There will continue to be the need to evaluate the knowledge level of prospective FMG entrants into graduate medical education in a manner which is consistent with expectations for graduates of U.S. medical schools.

Specific Recommendations

1. The United States Information Agency (USIA) in cooperation with the Educational Commission for Foreign Medical Graduates (ECFMG) should continue to improve the data base on exchange visitor physicians. Collated data must span across all sponsors.

2. USIA should guarantee that all sponsors of exchange visitor physicians emphasize the return home provisions of the programs.

3. USIA should convene an informal advisory group comprised of individuals from interested private and public organizations at least twice each year. This group will provide expert advice on the development of the annual report (required by statute) on the status of exchange visitor physicians in graduate medical education or training.

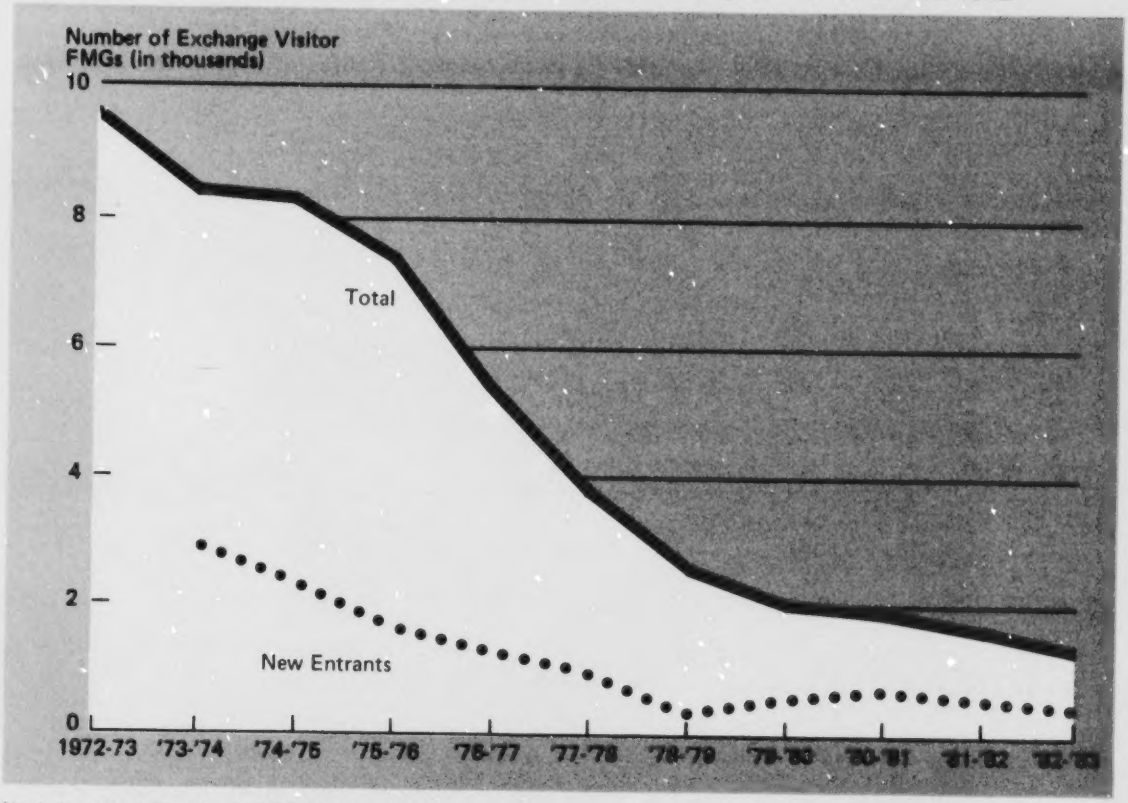
4. USIA in cooperation with ECFMG should establish a clearinghouse on current and projected future opportunities for exchange visitor physicians. Such a clearinghouse would foster the underlying purpose of all exchange programs. Furthermore, it would contribute to more realistic expectations abroad regarding the availablility of exchange visitor opportunities in the U.S.

5. Consideration should be given by USIA to providing U.S. support for expanded bilateral medical exchange visitor programs, especially in faculty development. The present Report documents the interest and need across many nations in pursuing physician training opportunities in the U.S. Physician exchange visitor programs can serve as the pathway for enhancement of medical education and subsequent improved medical care for participating nations. An administrative focus for coordinating medical education exchange visits should be established.

6. Based upon the information contained within this Report, physician exchange visitor programs are of value to both home countries as well as the U.S. The U.S. Public Health Service affirms that physician exchange visitor programs contribute to timely acquisition of information on advances from around the world in areas of clinical medicine, public health and medical research and the fostering of attitudes worldwide that the United States is vitally interested in the health and advancement of peoples of all nations.

ATTACHMENT 1

Number of ECFMG-Sponsored Exchange Visitor Foreign Medical Graduates in Graduate Medical Education or Training, Both New Entrants and Total, for the Years 1972-1982*



*Includes all individuals under ECFMG sponsorship by academic year. New entrant data for 1972-73 are not available. Total sponsored = new entrants + continuations from prior year. Data for 1982-83 are thru 9/7/82 and are still preliminary.

SOURCE: Educational Commission for Foreign Medical Graduates, September, 1982.

DEFINITIONS*

Exchange Visitor Program - A program of a sponsor designed to promote interchange of persons, knowledge and skills, and the interchange of developments in the field of education, the arts and sciences, and concerned with one or more categories of participants which has been designated to promote mutual understanding between the people of the United States and the people of other countries.

Exchange Visitor (J visa) - An alien, having a residence in a foreign country which he has no intention of abandoning, who is a bona fide student, scholar, trainee, teacher, professor, research assistant, specialist or leader in a field of specialized knowledge or skill, or other person of similar description, who is coming temporarily to the United States as a participant in an Exchange-Visitor Program.

J-1 Visa - The principal exchange visitor is designated as being in J-1 status.

J-2 Visa - The spouse and minor unmarried children are designated as being in J-2 status.

Sponsor - Any reputable U.S. Agency or organization or recognized international agency or organization having U.S. membership and offices which has had an approved program under its sponsorship designated as an Exchange-Visitor Program.

Immigrant** - An alien admitted for permanent residence.

Non-immigrant** - An alien admitted in temporary status. All exchange visitors are non-immigrants.

Participant - Any foreign national who has been selected by a sponsor to participate in an Exchange-Visitor Program and who is seeking to enter or has entered the United States temporarily on a J-1 visa, including but not limited to the categories listed below:

(a) Student - A person pursuing formal courses, or any combination of courses, research, or teaching, leading to a recognized degree or certificate, in an established school or institution of learning.

(b) Trainee - A person obtaining on-the-job training with firms, institutions and/or agencies in a specialized field of knowledge or skill for periods not to exceed 18 months.

(c) Teacher - A person teaching in established primary or secondary schools, or established schools offering specialized instruction.

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* Definitions excerpted from the Immigration and Nationality Act or adapted from ICA regulations (22 CFR 514.2).

** Adapted from the INS 1979 Statistical Yearbook, p. 7.

(d) Professor - A person teaching or conducting advanced research, or both, in an established institution of higher learning.

(e) Research Scholar or Specialist - A person who is engaging in a program for the purpose of undertaking or participating in research.

(f) International Visitor - A person who is engaging in a program for the purpose of travel, observation, consultation, research, training, sharing, or demonstrating specialized knowledge or skills or participating in organized people to people programs.

(g) Professional Trainee - A person who is engaging in a program for the purpose of clinical training in medical or allied fields.

"Fiscal Year" means the Federal fiscal year beginning October 1 and ending the following September 30. Prior to fiscal year 1976, the Federal fiscal began on July 1 and ended the following June 30.

Transition Quater (TQ) - The transition quarter for fiscal year 1976 covers the 3-month period, July 1 through September 30, 1976.

"Calander Year" means the year beginning January 1 and ending December 31.

"Academic Year" means the school year beginning July 1 and ending the following June 30.

ABBREVIATIONS

ECFMG - Educational Commission for Foreign Medical Graduates

FMG - Foreign Medical Graduate

GME - Graduate Medical Education

USIA - United States Information Agency

VQE - Visa Qualifying Examination

BACKGROUND

This Background Section provides an overview of the exchange visitor process. Exchange visitors are defined for the purpose of this report as nonimmigrants entering the United States under J-visa status for the purpose of educational or cultural exchange.

Although "J" visas have been issued by administrative arrangement since the 1950's, it was the Mutual Educational and Cultural Exchange Act of 1961 (P.L. 87-256) which incorporated "category J" into the basic immigration law as a special nonimmigrant visa category.

The new statutory J-visa provided nonimmigrant status for "an alien having a residence in a foreign country which he has no intention of abandoning who is a bona fide student, scholar, trainee, teacher, professor, research assistant, specialist, or leader in the field of specialized knowledge or skill, or other person of similar description, who is coming temporarily to the United States as a participant in a program designated by the Director, United States Information Agency, for the purpose of teaching, instructing or lecturing, studying, observing, conducting research, consulting, demonstrating special skills, or receiving training."* A detailed summary of legislation related to exchange visitor physicians is contained in the appendices to this Report.

The underlying purpose of exchange visitor programs is to improve and strengthen the international relations of the United States by stimulating mutual understanding through educational and cultural exchanges.**

There are at least 25 Federal Government Departments and Agencies operating international exchange or training programs. In addition, there are approximately 1,380 programs sponsored by national, state or local government agencies, educational institutions such as schools, colleges, universities, seminaries, libraries, museums, institutions devoted to scientific and technological research, hospitals and related institutions, nonprofit associations, foundations, institutes, and business and industrial concerns.

Of the above 1,400 sponsors of exchange visitors, over 230 provide sponsorship for exchange visitor physicians. Among the many possible sponsors of exchange visitor physicians, the Educational Commission for Foreign Medical Graduates (ECFMG) plays a special role. ECFMG is authorized by the United States Information Agency (USIA) to provide sponsorship for alien graduates of foreign medical schools who wish to pursue graduate medical education or clinical fellowship training in the United States.

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* New Section 101(a)(15)(J) of Immigration and Nationality Act

** USIA's Exchange Visitor Program Information Sheet.

The purpose of ECFMG is to assure that foreign medical graduates have met basic requirements to enter accredited programs of graduate medical education and training. ECFMG carries out this program of certification with the assistance of professional educational testing organizations.

The ECFMG certification program consists of:*

1. Verification of Applicant Identity

   This is accomplished through the close cooperation of United States Foreign Service Officers, medical school officials and other appropriate authorities, who certify that the information on the application form is correct.

2. Completion of Educational Requirements

   Applicants must have had at least four credit years (academic years for which credit has been given toward completion of the medical curriculum) in attendance at a foreign medical school that is listed at the time of graduation in the World Directory of Medical Schools, published by the World Health Organization. Also, they must have successfully completed the full medical curriculum prescribed by the medical school and by the country in which they have had their medical education. A national of the country concerned must have obtained an unrestricted license or certificate of full registration to practice medicine in that country.

3. Verification of Medical Credentials

   Applicants must document educational requirements in the form of medical school diplomas or other qualifications prescribed by the countries in which their medical schools are located. Documents are carefully examined and compared with certificates maintained in the ECFMG credential library.

   This library is the most comprehensive of its kind in the world, and information is updated, through communication with legally responsible officials of medical schools and nations, frequently with ministries of health. In addition, these same officials respond to ECFMG inquiries regarding the duration of foreign schools' curricula.

   The objective of credential evaluation is to assure that foreign medical graduates applying for ECFMG certification have successfully completed the full medical curriculum and have fulfilled all of the educational requirements to practice medicine in the country in which they had their medical education.

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* Adapted from policy statement on ECFMG Certification.

4. Successful Completion of Medical Science and English Language Proficiency Examinations*

Applicants must pass an examination in the basic and clinical medical sciences and an English language proficiency test. ECFMG administers the ECFMG medical science examination as well as the Visa Qualifying Examination (VQE). The VQE is accepted as an alternative to the ECFMG medical science examination for ECFMG certification.

The Visa Qualifying Examination was developed in response to 1976 and 1977 amendments to the Immigration and Nationality Act. These amendments established new requirements for the admission of alien physicians to the United States to perform medical services, or to receive graduate medical education or training. The provisions of these amendments, which affect the entry of alien graduates of foreign medical schools, require them to pass the National Board of Medical Examiners Part I and Part II examinations (or an examination determined to be equivalent by the Secretary of Health and Human Services) and to be competent in both oral and written English.

By policy of the National Board of Medical Examiners (NBME), only students or graduates of United States and Canadian medical schools accredited by the Liaison Committee on Medical Education are eligible to take the NBME Part I and Part II examinations.

In 1977, the Secretary determined that a special two-day examination, which was developed and offered by the National Board of Medical Examiners, and composed of approximately equal proportions of basic science and clinical science test items in their customary multiple-choice format, is equivalent to the NBME Part I and Part II examinations for the purpose of the law. Since it is necessary for most alien physicians to pass the special two-day examination as one of the requirements to obtain a visa to enter the United States, the examination has become known as the Visa Qualifying Examination (VQE).

Demonstration of competence in the English language is a requirement for ECFMG certification and to obtain a J-visa for an alien physician. ECFMG administers an English test which is accepted for both purposes. The ECFMG English test is adapted from the validated Test of English as a Foreign Language (TOEFL), prepared by the Educational Testing Service, Princeton, New Jersey. It is a multiple choice examination, consisting of three sections: comprehension of spoken English, English structure and vocabulary.

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* Adapted from the 1982 Visa Qualifying Examination Information Booklet, p. 4 and p. 11.

The listening comprehension section is administered through use of tape recordings of statements and conversations that relate to commonplace events in everyday life in this country. After applicants have listened to recorded material of different people speaking (usually three), they select the best response from a series of alternatives in the English test booklet.

The ECFMG English test also assesses the ability of applicants to use simple sentence structure correctly and to demonstrate knowledge of words and phrases in common usage but unrelated to the medical vocabulary.

To assure insofar as possible that candidates are proficient in English, ECFMG has determined that certificates of applicants will remain valid for no more than two years prior to entry into an accredited program of graduate medical education or training in the United States.

Certificates held by FMGs who are in residency programs in the U.S. remain valid indefinitely. Certificates which expire can be revalidated by meeting the ECFMG English language requirements (passing an ECFMG English test or demonstrating performance satisfactory to ECFMG on the Test of English as a Foreign Language (TOEFL).

As part of the overview of exchange visitor programs, a brief description of the actual mechanics of obtaining an exchange visitor visa (i.e., J-visa) is provided below.

Although the United States Information Agency has the overall responsibility for the exchange visitor program, the Department of State, the Department of Justice, the Immigration and Naturalization Service, and the Department of Health and Human Services also play a role in the administration of this program.

The U.S. consulate or embassy (Department of State) which has jurisdiction over the exchange visitor's place of residence is responsible for assuring that the applicant for a J-1 exchange visitor visa has a valid passport and a properly executed Form IAP-66 (Certificate of Eligibility for Exchange Visitor Status).

The consular officer may request additional information to establish that the applicant is a bona fide nonimmigrant exchange visitor and that he or she has adequate financial support and meets all of the other requirements for exchange visitor status, including having a residence in his home country which he has no intention of abandoning.

Upon entry of the exchange visitor to the U.S., the immigration inspector (Immigration and Naturalization Service, Department of Justice) disburses the IAP-66 to the appropriate offices and issues the Exchange Visitor Form I-94 (Arrival-Departure Record). This form indicates the date and place of his or her admission to the U.S., his or her classification, and the date to which his or her stay is authorized. The exchange visitor has, by this process, been lawfully admitted to the U.S. for the period indicated on Form I-94.

The following section of this Report to Congress will present findings related to exchange visitor physician programs. The Findings Section focuses on entry patterns of exchange visitor physicians, value to home countries, and value to the United States.

FINDINGS

With few exceptions, systematic and comprehensive studies on the effectiveness and value of physician exchange visitor programs to foreign nations and to the United States are lacking. While there is extensive literature on the topic of foreign medical graduates, prior studies have focused, for the most part, upon the impact on the U.S. supply of physicians and the roles of FMGs in the U.S. health care system.*

Hence, the findings section of this Report to Congress focuses upon collated data which address the value to foreign nations of physician exchange programs as well as meet the underlying purpose of exchange programs to improve and strengthen the international relations of the United States.

In many cases, from existing information, one can only indirectly assess the value of such programs to foreign nations. However, this represents an essential first step in addressing this complex topic.

In assembling the information for this Report, it was apparent that widespread misperceptions exist regarding physician exchange visitor programs. These misperceptions stem in part from reliance on data from the early 1970's on foreign medical graduates. Patterns of entry of FMGs today are markedly different from those of a decade ago. Furthermore, such misperceptions can partially be attributed to the prevalent tendency to overlook the underlying purpose of exchange visitor programs, as stated above: to improve and strengthen the international relations of the United States by enhancing mutual understanding through educational and cultural exchanges. Exchange programs by necessity must involve the movement of persons between countries for the purpose of sharing knowledges, skills, ideas and culture.

The format utilized in the findings section which follows was selected to enhance understanding of current information on exchange visitor physicians, to ameliorate misperceptions around this topic, as well as to focus possible discussion regarding recommendations for changes in legislation and regulations as may be appropriate.

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*A recent published summary monograph (June, 1981) in this area entitled, The Changing Role of the Foreign Medical Graduate in the the Practice of Medicine in the U.S., is included as an attachment to this Report to Congress.

ISSUES

1. ISSUE: Why are issues related to physician exchange visitors both timely and important?

FINDINGS:

- o Five years have passed since the Visa Qualifying Examination (VQE) was required for new entrant alien FMGs who wished to enter accredited graduate medical education (GME) programs.
- o Studies on FMGs have paid little attention to the value to home countries of physician exchange visitor programs.
- o Legislation related to the entry of alien physicians into the U.S. as exchange visitors spans over 35 years, and is quite involved. (See Attachment 1-A for highlights of statutory provisions from 1946 through 1981.)
- o U.S. international relations and foreign policy considerations are under critical re-evaluation.*
- o There is current concern regarding the adequacy of the projected future number of GME training positions to accommodate the expanded number of graduates from U.S. medical schools. This underscores the urgency of reviewing GME opportunities for exchange visitor physicians.
- o Based upon the above factors, an assessment of issues related to physician exchange visitor programs is both timely and important. Furthermore, the statutory change to include "such recommendations for changes in legislation and regulations as may be appropriate" offers a significant opportunity for timely follow-up on such an assessment.

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*As noted in the following excerpt from House Report 97-264 (page 24), this factor was explicitly of Congressional concern during legislative deliberations preceding P.L. 97-116:

> "Section 5(e) provides for an evaluation, and report to Congress within two years, on the value of graduate medical exchange programs to foreign countries and to the United States. The Committee is hopeful that future policymaking by the Executive Branch in this area be based on an assessment of the actual impacts of these programs on improving medical care delivery in foreign countries and on enhancement of the United States' foreign policy objectives."

ATTACHMENT 1-A

HIGHLIGHTS OF LEGISLATION RELATED TO ALIEN PHYSICIANS' ENTRY INTO THE UNITED STATES AS EXCHANGE VISITORS, 1946-1981

Law	Date of Enactment	Brief Summary of Provisions*
P.L. 79-584 (Fulbright Amendment), amending Surplus Property Act of 1944 (P.L. 78-457)	8/1/46	Provided for use of proceeds for disposal of property located in other countries for purpose of supporting educational exchange activities.
United States Information and Educational Exchange Act of 1948 (P.L. 80-402) (Smith-Mundt Act)	1/27/48	Authorized Secretary of State to provide for interchanges on a reciprocal basis between the U.S. and other countries of students, trainees, teachers, and others in fields of specialized knowledge or skill. Conditions for entry under sponsored programs to be established by regulation.
Immigration and Nationality Act of 1952 (P.L. 82-114)	6/27/52	Amended law relating to nonimmigrants, creating new categories for students (F visa) and temporary workers (H visa). Under this law, alien physician exchange visitors were admitted both under the H visa category and under a new J visa category that was created administratively for the specific purpose of covering exchange visitors under 1948 Smith-Mundt Act.
An Act to Amend the United States Information and Educational Exchange Act of 1948 (P.L. 84-555)	6/4/56	Educational exchange visitors required to return to country of origin or cooperating country for 2 years before converting to immigrant, H visa, or permanent resident status. Waiver authorized if in public interest.
Mutual Educational and Cultural Exchange Act of 1961 (P.L. 87-256)	9/21/61	J visa category incorporated into statutory law. Requirement for 2-year residence abroad amended to require that residence in a cooperating country be in accord with basic intent of exchange program.
Immigration and Nationality Act Amendments of 1965 (P.L. 89-236)	10/3/65	Repealed national origin quota provisions for Eastern Hemisphere immigrants and established new system of preference categories that favored members of professions and other persons with skills in short supply, making it easier for certain FMG exchange visitors (especially those from Asian countries) to convert to immigrant status.
Immigration and Nationality Act Amendments--Entry of Non-Immigrants (P.L. 91-225)	4/7/70	2-year foreign residence requirement for J visa FMGs wishing to convert status limited to exchange visitors financed by own or U.S. government, or who were from a country requiring their skills ("skills list"). Waiver authority broadened. Various changes made in law authorizing H visas for temporary workers.
Health Professions Educational Assistance Act of 1976 (P.L. 94-484)	10/12/76	Established new requirements for alien physicians entering U.S. as J visa exchange visitors for graduate medical education: educational auspices, passage of Parts I and II of the National Board of Medical Examiners' Examination or an equivalent examination (subsequently developed and labeled the Visa Qualifying Examination or VQE), English competency, commitment to return to own country, and limit on length of stay. Waiver of requirements authorized through 12/31/80 in case of "substantial disruption" of health services. Requirement that J visa visitor reside abroad for 2 years before conversion of status made more strict. New restrictions placed on entry of physicians as H visa exchange visitors for temporary work or training. Physicians entering as immigrants on basis of skills or as nonpreference immigrants also subject to examination requirements.

* A detailed summary of legislative provisions is provided as a separate attachment.

ATTACHMENT 1-A (Cont.)

Law	Date of Enactment	Brief Summary of Provisions
Immigration and Nationality Act Amendments of 1976 (P.L. 94-571)	10/20/76	Made various changes in immigration law affecting ability of exchange visitors to convert to immigrant status, e.g., extension to Western Hemisphere countries of preference category system, revised numerical restrictions, tightened requirements for immigrants receiving preference as members of professions (prearranged employment required), modified labor certification requirements for aliens who are teachers or have exceptional ability in arts or sciences.
Health Services Extension Act of 1977 (Title III of P.L. 95-83)	8/1/77	Postponed effective date of P.L. 94-484 J visa exchange visitor requirements to January 10, 1978, with substantial disruption waiver authority made applicable only to examination and educational auspices requirements. Alien graduates of U.S. and Canadian medical schools exempted from examination requirements. H visa restrictions relaxed for physicians "of national and international renown". Provided grandfather clause for examination requirements for alien physicians licensed, in practice, and specialty-certified in a State as of January 9, 1977.
Immigration and Nationality Act--Refugee Policy (P.L. 95-412)	10/5/78	Modified numerical ceilings for Eastern and Western Hemisphere immigrants.
Refugee Act of 1980 (P.L. 96-212)	3/17/80	Decreased overall numerical ceiling for immigrants.
Health Programs Extension Act of 1980 (P.L. 96-538)	12/17/80	Substantial disruption waiver authority for J visa exchange visitor requirements extended through 12/31/81.
Immigration and Nationality Act Amendments of 1981 (P.L. 97-116)	12/29/81	Length of stay of J visa physician exchange visitors extended to time typically required to complete residency training. Substantial disruption waiver authority extended through 12/31/83, with new requirements for comprehensive plans to reduce reliance on alien physicians. Secretary of HHS required to monitor issuance of waivers to assure, among other things, that quality care is provided and that participants receive appropriate supervision. Grandfather clause for examination requirements amended to delete requirement for specialty certification. New category of "special immigrant" established to ease conversion to immigrant status of physicians practicing in U.S. since before January 10, 1978. Reports to Congress required on substantial disruption waivers and exchange visitor programs.

2. ISSUE: Is there a single exchange visitor program for all alien foreign medical graduates?

FINDINGS:

- o There are over 230 sponsoring organizations for exchange programs for physicians representing a wide variety of organizations from the public and private sector. (See Attachment 2-A.)

- o There has been a variety of agencies and organizations which have funded international exchanges. (See Attachment 2-B.)

- o While the ECFMG is the leading sponsor for exchange visitor physicians, there are large numbers of new entrant exchange visitors sponsored by other institutions (see Attachments 2-C and 2-D). These institutions include the Pan American Health Organization, prestigious universities and medical centers nationwide, the National Institutes of Health, and the Agency for International Development.

- o While the underlying purpose is the same for all exchange visitor programs, there are wide variations in the goals and objectives of physician exchange visitor programs (see Attachments 2-E and 2-F for selected examples).

- o Any evaluation of effectiveness and value to foreign nations and to the United States of exchange programs for the graduate medical education or training of aliens must take into account the underlying purpose as well as the specific objectives for individual exchange programs.

ATTACHMENT 2-A

EXAMPLES OF THE WIDE RANGE OF SPONSORS
OF EXCHANGE VISITOR PHYSICIANS*

Educational Commission for Foreign Medical Graduates

More than 200 Universities - Nationwide

Pan American Health Organization

National Institutes of Health, DHHS

American Heart Association

United States Information Agency

Sloan-Kettering Institute

American Friends of the Middle East

Agency for International Development

National Academy of Sciences

Centers for Disease Control, DHHS

USA National Committee of the Lutheran World Federation

Department of Defense

Eye Research Institute of the Retina Foundation

The Rockefeller Foundation

American Association of University Women

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* Examples drawn from Fiscal Year 1981 data provided by USIA. Listing does not reflect rank order.

ATTACHMENT 2-B

Examples Of U.S. Government Agencies and International Organizations Which Have Funded International Exchange*

U.S. Government Agencies

1. Action
2. Agency for International Development
3. Atomic Energy Commission
4. Department of Agriculture
5. Department of Commerce
6. Department of Defense
7. Department of Health and Human Services
   - Food and Drug Administration
   - National Institutes of Health
8. Department of Housing and Urban Development
9. Department of the Interior
10. Department of Labor
11. United States information Agency
12. Department of Transportation
13. Drug Enforcement Administration
14. Environmental Protection Agency
15. Export-Import Bank of the United States
16. National Academy of Sciences
17. National Aeronautics and Space Administration
18. National Bureau of Standards
19. National Foundation on the Arts and Humanities
20. National Science Foundation
21. Smithsonian Institution
22. Veterans Administration

International Organizations

1. European Ecomonic Community
2. International Atomic Energy Agency
3. International Bank for Reconstruction and Development
4. International Civil Aviation Organization
5. International Labor Organization
6. International Monetary Fund
7. International Telecommunications Union
8. Inter-American Development Bank
9. Inter-Governmental Maritime Consultative Organization
10. North Atlantic Treaty Organization
11. Organization for Economic Cooperation and Development
12. Organization of African Unity
13. Organization of American States
14. Pan American Health Organization
15. United Nations
16. U.N. Children's Fund
17. U.N. Conference of Trade and Development
18. U.N. Development Program
19. U.N. Economic Commission for Africa
20. U.N. Economic Commission for Asia and Far East
21. U.N. Economic Commission for Europe
22. U.N. Economic Commission for Latin America
23. U.N. Economic and Social Council
24. U.N. Educational, Scientific and Cultural Organization
25. U.N. Food and Agriculture Organization
26. U.N. Industrial Development Organization
27. World Health Organization
28. World Meteorological Organization

Source: Adapted from Codes for Educational and Cultural Exchange, pp. 62-63, June, 1975; Department of State, Bureau of Educational and Cultural Affairs.

* While these programs are not specifically nor exclusively designed for physicians, physicians have participated in many of the above. Specific program break-out data are not available.

ATTACHMENT 2-C

EXAMPLES OF SPONSORS OF MORE THAN 40
NEW ENTRANT EXCHANGE VISITORS*
FISCAL YEAR 1981

Agency for International Development

Baylor University

Columbia University

United States Information Agency

Educational Commission for Foreign Medical Graduates

Harvard University

Johns Hopkins University

Massachusetts General Hospital

National Institutes of Health

Pan American Health Organization

Stanford University

State University of New York (S.U.N.Y. System)

University of California, Los Angeles

University of California, San Diego

University of California, San Francisco

University of Minnesota

University of Pennsylvania

University of Southern California

University of Texas, Austin

University of Washington

Yale University

Yeshiva University

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*Listed alphabetically, does not reflect rank order.

Source: USIA - Includes exchange visitors in medical research and FMGs pursuing advanced degrees.

ATTACHMENT 2-D

EXAMPLES OF SPONSORS OF BETWEEN 20 AND 40 NEW ENTRANT EXCHANGE VISITORS*, FISCAL YEAR 1981

Cleveland Clinic Educational Foundation
Centers for Disease Control (CDC)
Cornell University
Duke University
Mount Sinai Medical Center
New York University
Sloan-Kettering Institute
Scripps Clinic & Research Foundation
Tufts University
University of Alabama
University of Chicago
University of Cincinnati
University of Florida
University of Illinois
University of Iowa
University of Miami
University of Michigan
University of North Carolina
University of Pittsburgh
University of Wisconsin
Washington University, St. Louis

*Listed alphabetically, does not reflect rank order.

Source: USIA -- Includes exchange visitors in medical research and FMGs pursuing advanced degrees.

ATTACHMENT 2-E

NATIONAL INSTITUTES OF HEALTH EXCHANGE PROGRAMS

Program	Objectives	Selection Process	Maximum Length of Stay
NIH Visiting Programs: Visiting Fellow Visiting Associate Visiting Scientist	To offer talented scientists throughout the world the opportunity to share the resources of the NIH. Distinguished scientists at all levels of their careers are invited to NIH to receive advanced research experience or to conduct research in their biomedical specialities.	Invitational. Requests reviewed within the categorical Institutes and approved and awarded by the Director of NIH.	Visiting Fellow: 3 years Visiting Associate and Visiting Scientist: 4 years. Subject to visa limitations.
Guest Researchers (foreign)	To make research and study facilities readily available to the scientific community. Guest Researchers use NIH facilities to further their own research or training by using equipment and other resources not otherwise available to them.	Invitational. Requests are reviewed within the categorical Institutes and approved by the Scientific Director and the Institute Director.	3 years - subject to visa limitations.
Experts (foreign)	Allows NIH to obtain the services of experts in specialized or targeted areas of research (e.g. heart and cancer).	Invitational. Requests are reviewed in the categorical Institutes and approved by the Institute Director.	4 years - subject to visa limitations.
Fogarty Scholars-in-Residence Program	To invite internationally recognized scientists from the U.S. and abroad to NIH to work on projects in the health sciences related to a specific institute or an NIH-wide interest. Scholars interact with the staff of all NIH Institutes and research divisions, as well as with staff members of outside academic institutions.	Awards are made by the Director of FIC (Fogarty International Center), on the recommendation of an advisory panel representing the NIH Institutes.	10 months
International Research Fellows	To offer research fellowships to outstanding and relatively young biomedical scientists from many participating countries. Recipients come to U.S. laboratories under the sponsorship of a preceptor who provides the necessary laboratory space and guidance for the project. Individual must arrange for U.S. sponsor.	Nominated by a committee in the home country. Candidate then reviewed by NIH study section. Awarded by the Director, FIC.	Usually 1 year.
Exchange Scientists: Collaborative Research under Bilateral Agreements	To paticipate with other U.S. agencies in bilateral cooperative agreements between the U.S. Government and a number of other countries. Such agreements include scientist exchanges, Special Foreign Currency Program activities (PL.480), and, in some instances, the conduct and coordination of cooperative research projects which are undertaken through regular support mechanisms. Coordination is achieved through joint workshops and conferences as well as visits between principal investigators.	Individuals submit a proposal for consideration that is acceptable to both U.S. and participating country. (Egypt, France, Federal Republic of Germany, Hungary, India, Israel, Italy, Japan, Poland, Romania, U.S.S.R., Spain, People's Republic of China, and Yugoslavia.)	Variable - subject to visa limitations.

ATTACHMENT 2-F

CENTERS FOR DISEASE CONTROL
EXCHANGE PROGRAMS*

VISITING ASSOCIATE

Provides promising scientists the opportunity to strengthen mutually productive relationships between professional health staff of the Centers for Disease Control (CDC) and their counterparts working on the staff of universities, or public and private organizations, engaged in health research. Initial appointments may be for varying periods, not to exceed two years. Extensions on a yearly basis, not to exceed two such extensions may be made under certain conditions. Upon completion of the fellowship, non-resident aliens are required to return to the country from which they came.

VISITING SCIENTIST

Provides distinguished scientists and investigators, who have unusual knowledge or experience required in a specific program, the opportunity to work in health research, investigations, or studies to broaden the utility of the physical facilities and the intellectual environment of CDC. Initial appointments may be for varying periods of time, not to exceed two years. Extensions on a yearly basis, not to exceed two such extensions may be made under certain conditions. Upon completion of the fellowship, non-resident aliens are required to return to the country from which they came.

VISITING FELLOW

Provides and encourages training for research relating to the physical and mental diseases and impairments of man; the organization, provision, and financing of health services; and communication of information. Also provided are scientific projects for the compilation of existing, or writing of original contributions relating to scientific, social, or cultural advancements in sciences related to health. Initial awards shall be for a period not to exceed one year. One or more continuation awards for an additional period may be made upon a finding of satisfactory progress toward accomplishment of the purposes of the initial award, but may not exceed a total of three years. Upon completion of the fellowship, non-resident aliens are required to return to the country from which they came.

GUEST RESEARCHER

Makes CDC research facilities available to qualified research investigators who desire to take part in CDC research investigations or to carry out their own research through the use of CDC facilities. The basis for acceptance of an outside investigator rests on complementary professional interests, appropriate facilities, and the prospect of mutual benefit to the CDC and the investigator. Research studies must be consistent with the mission and objectives of the CDC and not interfere with regular functions.

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* CDC Exchange Programs currently under revision. Telecommunication from Commissioned Corps and Fellow Program Section, PMO, CDC, August 30, 1982.

3. ISSUE: Are exchange visitor FMGs still entering residency training in the U.S. each year in large numbers?

FINDINGS:

- o In the early 1970's, several thousand exchange visitor FMGs annually came to the U.S. to pursue residency training. The number of exchange visitor FMGsin GME has fallen dramatically over the last decade. (See Attachment 3-A.)

- o In academic year 1981-82, only 544 physicians were sponsored by ECFMG as new entrant exchange visitors. (See Attachment 3-B). This is in sharp contrast to the high* of 2,917 new entrants in academic year 1973-74.

- o Wide intercountry variations exist in entry patterns of ECFMG-sponsored FMGs. For the 9-year interval of academic years 1973-74 to 1981-82, five countries comprised 40 percent of all new entrant exchange visitor FMGs (i.e., 4,397 from 5 countries versus 6,530 from all other nations worldwide). These five countries in rank order were: Canada, the Philippines, India, Iran, and China (Taiwan), Canada alone accounted for 11 percent of all exchange visitor FMGs. (See Attachment 3-C.)

- o For the years academic years 1973-74 to 1981-82, 15 countries accounted for two-thirds of all new entrant exchange visitor physicians sponsored by ECFMG. (See Attachment 3-D.)

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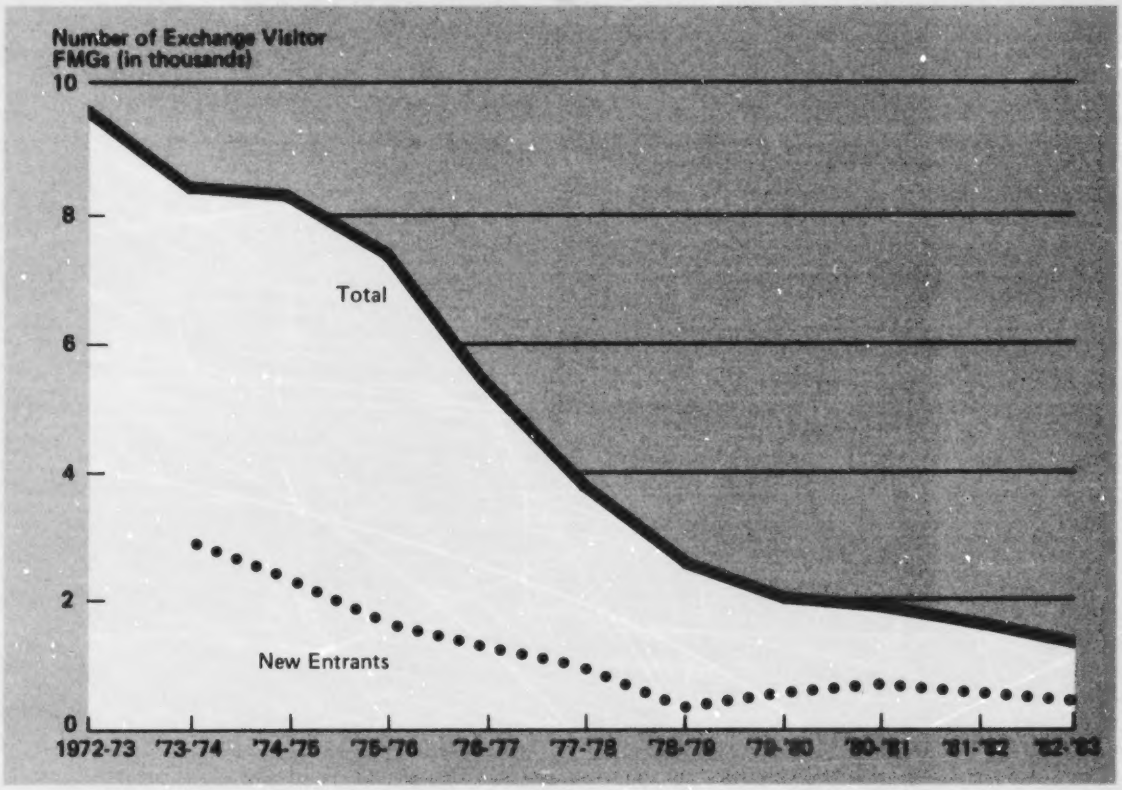
*Reliable data on new entrant ECFMG-sponsored exchange visitors were available only for academic years 1973-74 to 1981-82.

ATTACHMENT 3-A

Number of ECFMG-Sponsored Exchange Visitor Foreign Medical Graduates in Graduate Medical Education or Training, Both New Entrants and Total, for the Years 1972-1982*



*Includes all individuals under ECFMG sponsorship by academic year. New entrant data for 1972-73 are not available. Total sponsored = new entrants + continuations from prior year. Data for 1982-83 are thru 9/7/82 and are still preliminary.

SOURCE: Educational Commission for Foreign Medical Graduates, September, 1982.

ATTACHMENT 3-B

ECFMG-SPONSORED EXCHANGE VISITOR FMGs:
NEW ENTRANTS AND TOTAL SPONSORED, ACADEMIC YEARS 1972-73 TO 1981-82

Academic Year	New Entrants	Number of Countries Represented	Total FMGs Sponsored*
1972-73	NA	109	9,474
1973-74	2,917	101	8,369
1974-75	2,337	92	8,270
1975-76	1,628	88	7,389
1976-77	1,196	88	5,311
1977-78	901	81	3,660
1978-79**	296	54	2,557
1979-80	442	65	2,020
1980-81	666	73	1,890
1981-82	544	66	1,552
1982-83[a/]	412	NA	1,292

* Total sponsored = new entrants + continuations from prior year.

** First year that VQE certification was required for new entrant alien FMGs.

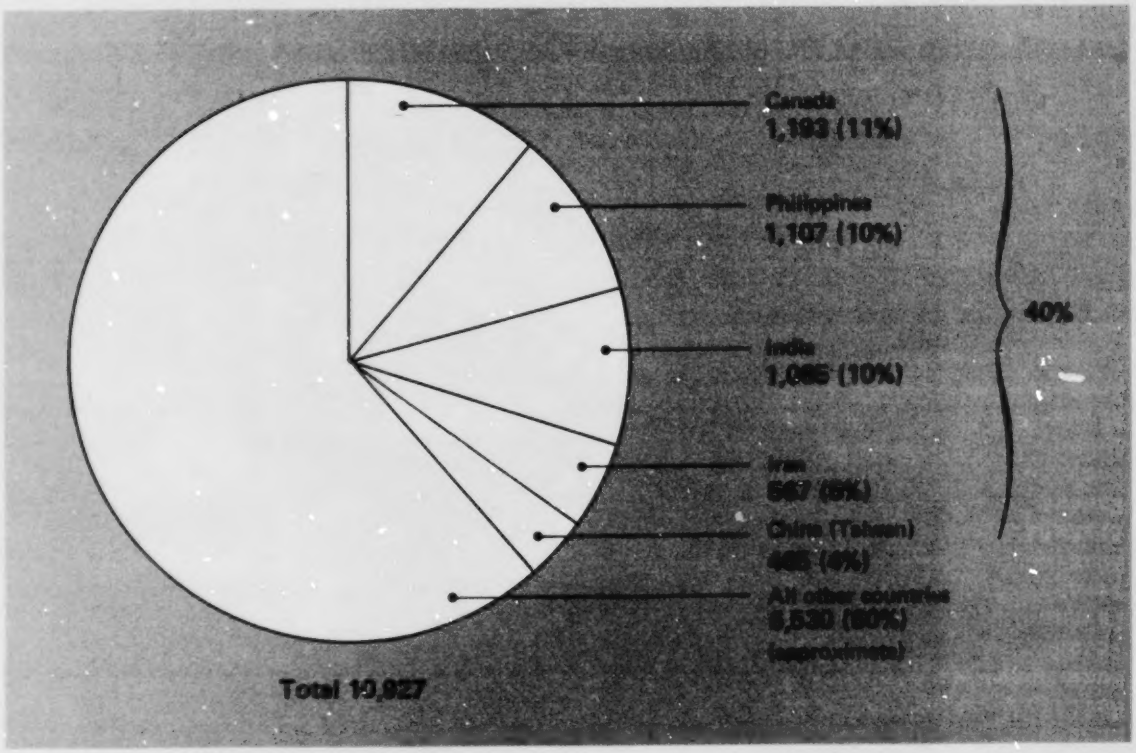
a/ Through September 7, 1982 - preliminary data.

SOURCE: Educational Commission for Foreign Medical Graduates, September, 1982.

NA = Not Available.

ATTACHMENT 3-C

Distribution of Total Number New Entrant Exchange Visitor FMGs
(ECFMG-Sponsored), 1973-1982



SOURCE: Educational Commission for Foreign Medical Graduates, August, 1982

ATTACHMENT 3-D

ECFMG-SPONSORED EXCHANGE VISITOR FMGs:
TOP 15 RANKING COUNTRIES OF
CITIZENSHIP FOR THE 9 - YEAR INTERVAL
ACADEMIC YEARS 1973-74 TO 1981-82

Rank Order	Country	Number of New Entrants Over 9-Year Period: Academic Years 1973-74 To 1981-82	Percent of All New Entrants	Cumulative Percent of Total
1	Canada	1,193	10.9	10.9
2	Philippines	1,107	10.1	21.0
3	India	1,065	9.7	30.7
4	Iran	567	5.2	35.9
5	China (Taiwan)	465	4.3	40.2
6	Great Britain	418	3.8	44.0
7	Japan	335	3.1	47.1
8	Australia	328	3.0	50.1
9	Argentina	295	2.7	52.8
10	Mexico	274	2.5	55.3
11	Thailand	271	2.5	57.8
12	Israel	252	2.3	60.1
13	Brazil	238	2.2	62.3
14	Syria	237	2.2	64.5
15	Lebanon	209	1.9	66.4
	All Other Countries	3,673	33.6	100%
	Total	10,927	100%	100%

Source: ECFMG, September, 1982. Listing includes all countries with 200 or more new entrants during the 9-year interval.

4. ISSUE: Do most exchange visitor FMGs come to the U.S. for residency training, i.e., accredited graduate medical education (GME)?

FINDINGS:

- Since 1979, approximately 400-600 exchange visitor physicians per year have entered residency training.

- Approximately 70,000 to 80,000 exchange visitors (i.e., J-visa status) were in the U.S. in any given year since 1979. Of this number, at least 4,500 were FMGs. This number includes an estimated 2,500 new entrants each year plus continuations from prior years. (See Attachment 4-A.)

- Thus, of the estimated number of new entrant exchange visitor FMGs each year, only 20 percent enter residency training.

- Of all non-immigrant aliens (exchange visitors and others) admitted to the U.S. annually (approximately 8 to 9 million), less than one in 15,000 are exchange visitor FMGs entering residency training. (See Attachment 4-B.)

- By way of further illustration of the diversity of sponsors of exchange visitor FMGs, data for the Centers for Disease Control (CDC) are provided in Attachments 4-C and 4-D.

ATTACHMENT 4-A

AGGREGATE DATA* ON EXCHANGE VISITOR FMGs
FISCAL YEAR 1981

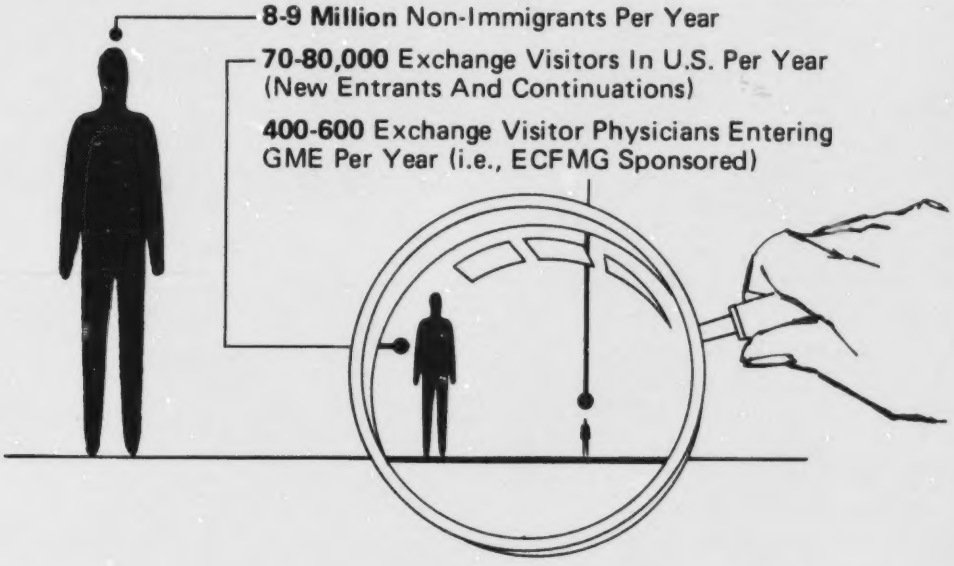
Total Number Exchange Visitor FMGs a/	over 4,500
New Entrant Exchange Visitor FMGs a/	2,500
New Entrant Exchange Visitor FMGs Entering GME	544

* Sources: USIA and ECFMG. Owing to asynchrony in data collection and coding difficulties, data must be viewed as rough approximations only.

a/ Coded by major field = Medicine (excluding oral surgery and clinical pharmacology); includes minor field of medical research.

ATTACHMENT 4-B

Proportional Relationships of Exchange Visitor FMG's in GME
to Total Number Exchange Visitors and Total Number
Non-immigrant Aliens Admitted to U.S. Annually


8-9 Million Non-Immigrants Per Year
70-80,000 Exchange Visitors In U.S. Per Year
(New Entrants And Continuations)
400-600 Exchange Visitor Physicians Entering
GME Per Year (i.e., ECFMG Sponsored)

ATTACHMENT 4-C

EXCHANGE VISITOR PHYSICIANS
SPONSORED BY THE
PAN AMERICAN HEALTH ORGANIZATION*

Country	1975 Number of Exchange Visitor Physicians in Programs of: Less Than One Academic Year	1975 Number of Exchange Visitor Physicians in Programs of: More Than One Academic Year	1981 Number of Exchange Visitor Physicians in Programs of: Less Than One Academic Year	1981 Number of Exchange Visitor Physicians in Programs of: More Than One Academic Year
Afghanistan	1	-	-	-
Algeria	2	-	-	-
Argentina	5	-	5	-
Australia	1	-	1	-
Bangladesh	1	-	-	-
Belguim	1	-	-	-
Belize	-	-	1	-
Bolivia	-	-	1	1
Brazil	7	2	9	-
Burma	-	-	2	-
Canada	2	-	1	-
Chile	10	-	6	-
China (Mainland)	-	-	35	-
Colombia	2	1	5	-
Costa Rica	1	-	1	-
Cuba	-	-	3	-
Czechoslovakia	1	-	-	-
Dominican Republic	1	-	-	-
Ecuador	1	-	5	-
Egypt	6	-	5	-
Ethiopia	-	-	1	-
Fed. Rep. of Germany	1	-	-	-
French Guiana	2	-	-	-
French Polynesia	1	-	-	-
France	1	-	1	-
Ghana	-	-	3	-
Haiti	-	-	1	-
Hong Kong	1	-	1	-
India	6	-	14	-
Indonesia	4	-	14	-
Iran	5	-	-	-
Iraq	4	-	-	-
Ireland	3	-	1	-
Israel	5	-	7	-
Jamacia	-	-	3	-
Japan	2		3	-
Jordan	-	-	1	-

* Source: Division of Human Resources and Research; Pan American Health Organization, October, 19, 1982.

ATTACHMENT 4-C (Cont.)

Country	1975 Number of Exchange Visitor Physicians in Programs of: Less Than One Academic Year	1975 More Than One Academic Year	1981 Number of Exchange Visitor Physicians in Programs of: Less Than One Academic Year	1981 More Than One Academic Year
Korea	-	-	2	-
Lebanon	-	-	3	-
Malaysia	7	-	4	1
Mexico	5	1	5	-
Nepal	-	-	4	-
Netherlands	1	-	-	-
New Hebrides	1		-	-
New Zealand	-	-	1	-
Nigeria	4	-	-	-
Panama	-	-	1	-
Pakistan	2	-	12	-
Philippines	13	-	8	-
St. Vincent	-	-	1	-
Sierra Leone			1	-
Singapore	4	-	1	-
South Africa	-	-	1	-
Sri Lanka	6	-	7	1
Sudan	-	-	5	-
Suriname	1	1	1	-
Sweden	-	-	1	-
Switzerland	1	-	-	-
Thailand	2	1	10	-
Tokelau	-	-	1	-
Trindidad and Tabagu	-	-	1	-
Trust Terr. of the Pac	1	-	-	-
Uganda	3	-	-	-
United Kingdom	1	-	1	-
USSR	1	-	-	-
Tonga	-	1	-	-
Venezuela	2	-	5	-
Total	132	7	206	3

TABLE 4-D

NEW ENTRANT EXCHANGE VISITOR FMGs AT THE
CENTERS FOR DISEASE CONTROL,
1980 THRU 1982*

Calendar Year	Total Number New Entrants
1980	21
1981	26
1982**	20

* Source: Commissioned Corps and Fellow Program Section, PMO, Centers for Disease Control.

** As of June 25, 1982.

5. ISSUE: What changes have occurred in entry patterns of exchange visitor FMGs into accredited GME since introduction of the Visa Qualifying Examination (VQE) and limitations were placed on individual length of stay?

FINDINGS:

- In academic year 1978-79, the number of new entrant exchange visitor physicians entering accredited GME was only 296, the lowest number in a decade. This was the first year that VQE certification was required for new entrants. (See Attachment 3-B, p. 19.)

- In contrasting academic years 1973-74 to 1976-77 with academic years 1978-79 to 1981-82, all but one of the 30 leading countries (Canada) showed significant decreases in numbers of new entrants.

- For 18 of these 30 countries, the decrease was greater than 80 percent. (See Attachment 5-A.) The remaining 11 countries demonstrated decreases ranging from 38 percent to 79 percent.

- The individual country decreases between 4-year intervals were often striking. The number of new entrants from India decreased by 91 percent from 949 (academic years 1973-74 to 1976-77) to only 82 (academic years 1978-79 to 1981-82); Iran, by 98 percent, from 507 to 10; China (Taiwan) by 91 percent, from 404 to 37; and the Philippines, by 83 percent, from 903 to 152.

- Examples of other countries which showed a striking decrease in the number of new entrants include: Thailand, from 243 to 23; Mexico, from 224 to 23; and Colombia, from 106 to only 5. (See Attachment 5-B.)

- Across all nations, only 6 countries showed an increased number of new entrant exchange visitor physicians between these two four-year intervals (academic years 1973-74 to 1976-77 versus academic years 1978-79 to 1981-82 (See Attachment 5-C.)

- For academic year 1981-82, for ECFMG-sponsored new entrant exchange visitor physicians, Canada ranked first, Australia, third and the United Kingdom, sixth. See Attachment 5-D for selected trend data on English-speaking nations.

ATTACHMENT 5-A

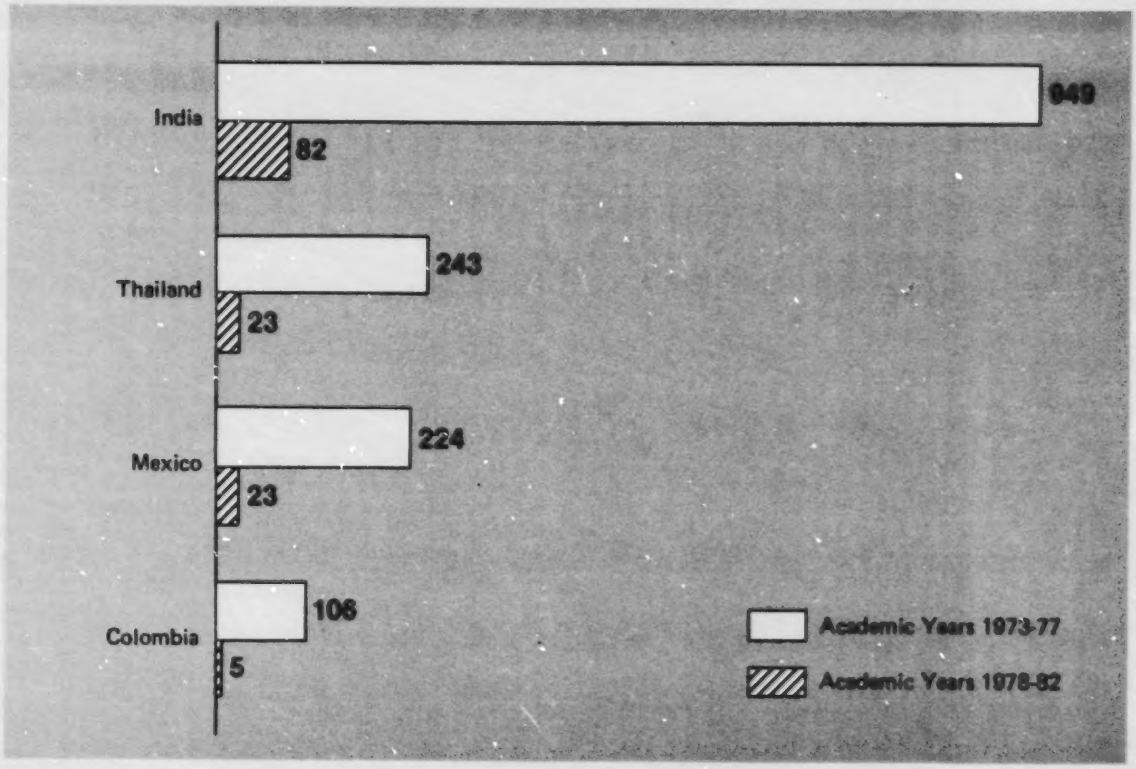
COUNTRIES DEMONSTRATING A DECREASE GREATER
THAN 80 PERCENT IN EXCHANGE VISITOR FMGs
ACADEMIC YEARS 1973-74 TO 1976-77 CONTRASTED TO
ACADEMIC YEARS 1978-79 TO 1981-82

Country	Numbers of New Entrants for Academic Years 1973-74 to 1976-77	Number of New Entrants for Academic Years 1978-79 to 1981-82	Percent Decrease
India	949	82	91%
Philippines	903	152	83%
Iran	507	10	98%
China (Taiwan)	404	37	91%
Japan	270	34	87%
Argentina	245	16	93%
Thailand	243	23	91%
Mexico	224	23	90%
Syria	194	31	84%
Brazil	193	22	89%
Peru	151	23	85%
Pakistan	134	21	84%
Chile	117	11	91%
Colombia	106	5	95%
Jordan	105	16	85%
South Korea	80	13	84%
Spain	79	13	84%
Haiti	70	6	91%

Source: ECFMG, August, 1982.

ATTACHMENT 5-B

Examples of Four Countries Demonstrating a Decrease Greater Than 90 Percent in New Entrant Exchange Visitor FMGs (ECFMG-Sponsored), 1973-77 Contrasted to 1978-82



SOURCE: Educational Commission for Foreign Medical Graduates, August, 1982

ATTACHMENT 5-C

ECFMG-SPONSORED EXCHANGE VISITOR FMGs, SELECTED DATA FOR COUNTRIES SHOWING AN INCREASED NUMBER OF NEW ENTRANTS FOR ACADEMIC YEARS 1973-74 TO 1976-77 VERSUS ACADEMIC YEARS 1978-79 TO 1981-82

Country	Number of New Entrants for Academic Years 1973-74-1976-77 (i.e., 4 years)	Number of New Entrants for Academic Years 1978-79-1981-82 (i.e., 4 years)
Canada	515	569
Ghana	21	27
New Zealand	19	20
Algeria	1	7
Zaire (Congo)	0	2
Burma	0	2

Source: ECFMG, August 1982.

ATTACHMENT 5-D

DATA FROM SELECTED ANGLOPHONE COUNTRIES
ON ECFMG-SPONSORED NEW ENTRANT
EXCHANGE VISITOR FMGs

Country	Number of New Entrants: Academic Year 1981-1982	Number of New Entrant: Academic Years 1973-74-1977-78 (i.e., 5 years)	Number of New Entrants: Academic Year 1978-79-1981-82* (i.e., 4 years)
Australia	32	221	107
Canada	123	624	569
Great Britain	21	337	81
Ireland	5	104	22
New Zealand	9	26	20
Nigeria	2	71	20

*VQE first required in 1978 for new entrants pursuing graduate medical education.

Source: ECFMG, August 1982. Countries listed alphabetically.

6. ISSUE: Do exchange visitors entering accredited residencies meet statutory* entry requirements?

FINDINGS:

- o FMGs are required to have ECFMG certification (for complete discription of ECFMG certification see pages 2-4) in order to participate in accredited (i.e., Accreditation Council for Graduate Medical Education: ACGME) programs of graduate medical education.

- o Graduates of Canadian medical schools do not take the VQE since these schools are accredited jointly by the Liaison Committee on Medical Education (LCME) and the Committee on Accreditation of Canadian Medical Schools (CACMS). The LCME is the accrediting agency for all U.S. medical schools.

- o Graduates of Canadian medical schools comprised over 20 percent of all new entrant ECFMG-sponsored exchange visitors for academic year 1981-82. (See Attachment 6-A.)

- o Aliens who were graduates of U.S. Medical Schools comprised only two (2) percent of new entrant ECFMG-sponsored exchange visitors for academic year 1981-82. (See Attachment 6-B.)

- o Based upon the above findings, exchange visitors entering accredited graduate medical education programs do meet statutory entry requirements.

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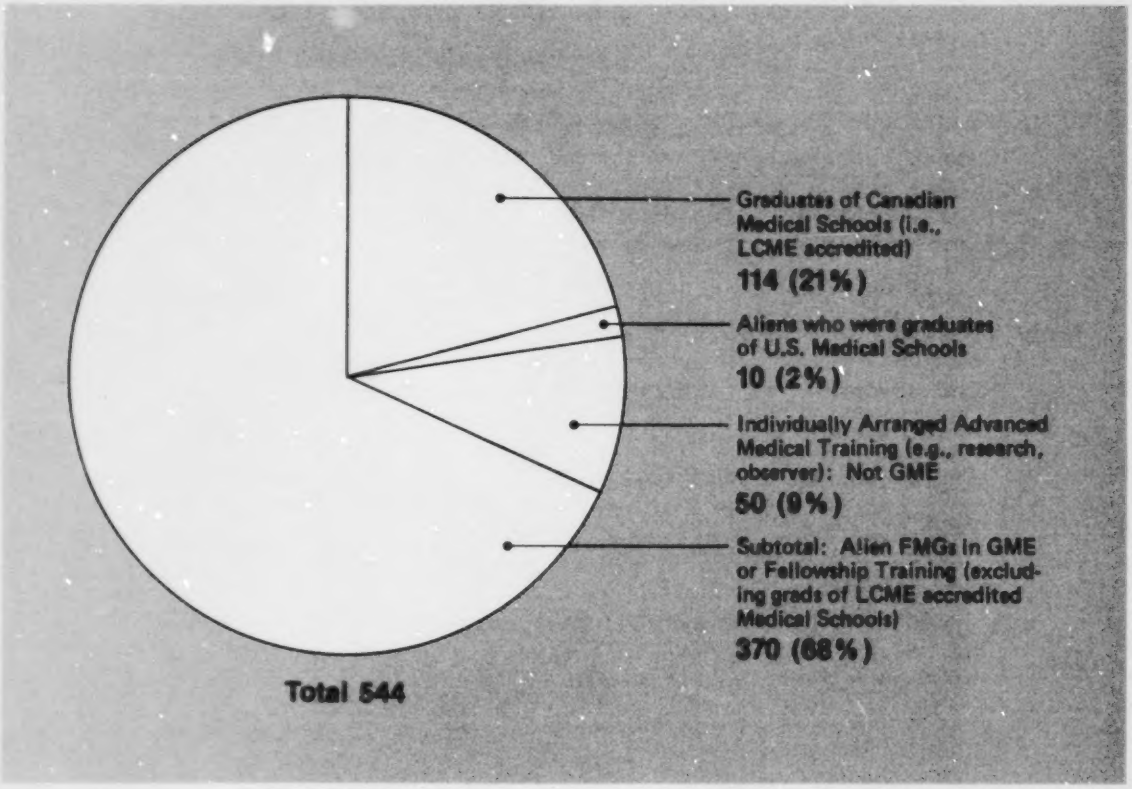
* i.e., under P.L. 94-484 and subsequent amendments.

ATTACHMENT 6-A

ECFMG-Sponsored Exchange Visitor Physicians: New Entrants for Academic Year 1981-82


Graduates of Canadian Medical Schools (i.e., LCME accredited)
114 (21%)
Aliens who were graduates of U.S. Medical Schools
10 (2%)
Individually Arranged Advanced Medical Training (e.g., research, observer): Not GME
50 (9%)
Subtotal: Alien FMGs in GME or Fellowship Training (excluding grads of LCME accredited Medical Schools)
370 (68%)
Total 544

SOURCE: Educational Commission for Foreign Medical Graduates, September, 1982.

ATTACHMENT 6-B

ECFMG-SPONSORED EXCHANGE VISITOR PHYSICIANS: NEW ENTRANTS

For Academic Year 1981-82

Total	544
Graduates of Canadian Medical Schools (i.e., LCME accredited)	114*
Aliens who were graduates of U.S. Medical Schools	10*
Individually Arranged Advanced Medical Training (e.g., research, observor): Not GME	50*
Subtotal: Alien FMG's in GME or Fellowship Training (excluding grads of LCME accredited Medical Schools)	370

* Not required to take VQE

Source: Educational Commission for Foreign Medical Graduates, September, 1982.

7. ISSUE: Have statutory requirements* established in the 1970s for exchange visitor physicians affected the total number of FMGs in accredited graduate medical education (GME) programs?

FINDINGS:

- o While the number of exchange visitor physicians in GME has decreased dramatically, the total number of FMGs in GME positions has remained at 12,000 to 13,000 per year over the last 5 years, academic years 1977-78 to 1981-82. (See Attachment 7-A.)

- o This plateau has occurred owing to the continuing entry of immigrant FMGs as well as the increased number of returning U.S.-citizen FMGs. (See Attachment 7-A.)

- o For academic year 1981-82, the number of U.S.-citizen FMGs in GME positions (across all years of training) was 5,778 in contrast to only 1,552 ECFMG-sponsored exchange visitor FMGs (across all years of training) for the same academic year.

- o The number of alien physicians in GME who are not exchange visitors has remained at over 5,000 annually (i.e., total across all years of residency).

- o For the latest year (i.e., FY 1979) for which Immigration and Naturalization Service (INS) data is available for comparison, there were 7 times as many immigrant physician entrants (3,040) as exchange visitor physicians (420). (See Attachment 7-B.)

- o For fiscal year 1976, the 10 leading countries contributing immigrant physicians to the U.S. exceeded (often by many fold) the number of new entrant exchange visitors entering GME from that country. (See Attachment 7-C.)

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* Provisions of P.L. 94-484 and subsequent amendments.

ATTACHMENT 7-A

INTERNS AND RESIDENTS IN ACCREDITED
GRADUATE MEDICAL EDUCATION (GME) PROGRAMS
Selected Data: 1972-1982

Academic Year	Total Filled GME Positions	Foreign Medical Graduates			
		Filled by FMGs	Total Number of Exchange Visitors	USFMGs	Alien FMGs Not Exchange Visitors
1972-73	56,244	18,395	9,474	NA	NA
1973-74	60,113	18,348	8,369	NA	NA
1974-75	62,512	18,131	8,270	NA	NA
1975-76	NA	NA	7,389	NA	NA
1976-77	60,561	15,496	5,311	NA	NA
1977-78	56,019	13,709	3,660	NA	NA
1978-79	63,163	12,821	2,557	NA	NA
1979-80	64,615	12,065	2,020	4,229	5,816
1980-81	61,819	12,078	1,890	4,790	5,398
1981-82	67,868	13,194	1,552	5,778	5,864

NA = Data not available

Sources: Data for 1972-1980: from the ECFMG, August, 1982 and excerpted and updated from The Changing Role of the Foreign Medical Graduate in the Practice of Medicine in the U.S., pp. 11 & 15, ECFMG; 1981.

Data for 1979-1982: 1982-1983 Directory of Residency Training Programs, pp. 59 & 63, American Medical Association; 1982.

ATTACHMENT 7-B

FOREIGN-BORN PHYSICIANS ADMITTED TO THE UNITED STATES AS IMMIGRANTS
THE TEN LEADING COUNTRIES OF BIRTH

FISCAL YEAR 1978*

	Country	Number of Physicians Admitted as Immigrants	Percent of Total	Cumulative Percent
1.	India	684	15.4	15.4
2.	Philippines	602	13.6	29.0
3.	Canada	449	10.1	39.1
4.	China (Mainland)	158	3.6	42.7
5.	United Kingdom	115	2.6	45.3
6.	Mexico	99	2.2	47.5
7.	Cuba	95	2.1	49.6
8.	Argentina	93	2.1	51.7
9.	Korea	88	2.0	53.7
10.	Chile	67	1.5	55.2
	All Other Countries	1,985	44.8	100
	Total	4,435	100	100

*i.e., 10/1/77 through 9/30/78

Source: Adapted from "The Changing Role of the Foreign Medical Graduate in the Practice of Medicine in the U.S."; p. 18. ECFMG: 1981.

ATTACHMENT 7-C

FOREIGN-BORN PHYSICIANS ADMITTED TO THE UNITED STATES AS IMMIGRANTS FOR THE TEN LEADING COUNTRIES OF BIRTH CONTRASTED TO ECFMG-SPONSORED NEW ENTRANT EXCHANGE VISITOR FMGs: 1976*

	Country	Number of Physicians Admitted as Immigrants	Number of ECFMG Sponsored New Entrant Exchange Visitor Physicians
1.	India	2,038	135
2.	Philippines	899	190
3.	Korea	240	23
4.	Pakistan	234	18
5.	United Kingdom	154	69
6.	China (Mainland)	143	1
7.	Argentina	111	43
8.	Thailand	107	28
9.	Cuba	104	0
10.	Canada	86	36
	All Other Countries	2,068	1,085
	Total	6,184	1,628

* Time frames comparable: FY 1976 and academic year 1975-76 (i.e., 7/1/75 through 6/30/76).

Sources: Data on New Entrants from the ECFMG and data on Immigrants adapted from "The Changing Role of the Foreign Medical Graduate in the Practice of Medicine in the U.S."; p.19. ECFMG: 1981.

8. ISSUE: Is further restriction on the entry of exchange visitor physicians an effective way to address FMG issues?

FINDINGS:

- As noted previously, there has been a significant fall in the number of exchange visitor physicians in GME over the last 10 years. Furthermore, there has been a significant reduction in the number of countries represented. (See Attachment 3-B, page 25).

- In FY 1978, the number of immigrant physicians admitted from just two countries (India and the Philippines) was larger than the total number of exchange visitors from across 81 countries (i.e., 1,286 versus 901)[a/]. (See Attachment 8-A.)

- For the purpose of examining trends, data 5 years prior to FY 1978, (i.e., in FY 1973), reveal that 4 countries (India, the Philippines, Korea, and Iran) collectively accounted for over 50 percent of all admitted immigrant physicians (3,643 out of 7,097); furthermore, 10 countries accounted for over 70 percent (i.e., 4,983 immigrant physicians admitted to the U.S. out of a total of 7,097). (See Attachment 8-B.)

- The number of new entrant exchange visitor FMGs[b/] in academic year 1981-82 in accredited GME programs represented only two (2) percent of the total number of PGY-1 residents (i.e., 370 out of 18,331).[c/]

- Based upon the findings listed under Issues 7 and 8, further restrictions on the entry of exchange visitor physicians would have little effect in reducing the aggregate number of FMGs in GME.

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a/ Data only roughly comparable owing to the slight asynchrony in time-interval, i.e., FY 1978 (10/1/77 through 9/30/78) versus academic year 1977-78 (7/1/77 through 6/30/78).

b/ i.e., Alien FMGs in GME excluding graduates of LCME accredited medical schools. (See Issue 3, pages 17-21).

c/ Figure of 18,331 represents the number of postgraduate-year-one (PGY-1) residents on duty 9/1/81 in those specialties (including flexible programs) open to physicians with no previous postgraduate medical training. (Source: 1982-83 Directory of Residency Training Programs, p. 60.)

ATTACHMENT 8-A

FOREIGN-BORN PHYSICIANS ADMITTED TO THE UNITED STATES AS IMMIGRANTS FOR THE 15 LEADING COUNTRIES OF BIRTH CONTRASTED TO ECFMG-SPONSORED NEW ENTRANT EXCHANGE VISITOR FMGs: 1978

	Country	Number of Physicians Admitted as Immigrants*	Number of ECFMG Sponsored New Entrant Exchange Visitor Physicians**
1.	India	684	34
2.	Philippines	602	52
3.	Canada	449	109
4.	China (Mainland)	158	2
5.	United Kingdom	115	55
6.	Mexico	99	27
7.	Cuba	95	0
8.	Argentina	93	34
9.	Korea	88	8
10.	Chile	67	20
11.	Pakistan	66	5
12.	Iran	65	50
13.	Peru	63	17
14.	China (Taiwan)	51	24
15.	Poland	43	2
	All Other Countries	1,697	462
	Total	4,435	901

*FY 1978 data (i.e., 10/1/77 through 9/30/78).

**Academic year 1977-78 (i.e., 7/1/77 through 6/30/78). Thus, time frames are slightly asynchronous.

Sources: Data on New Entrants from ECFMG and data on immigrants adapted from "The Changing Role of the Foreign Medical Graduate in the Practice of Medicine in the U.S."; p.18. ECFMG: 1981.

ATTACHMENT 8-B

FOREIGN-BORN PHYSICIANS ADMITTED TO THE UNITED STATES AS IMMIGRANTS
THE TEN LEADING COUNTRIES OF BIRTH

FY 1973

	Country	Number of Physicians Admitted as Immigrants	Percent of Total	Cumulative Percent
1.	India	1,921	27.1	27.1
2.	Philippines	753	10.6	37.6
3.	Korea	610	8.6	46.3
4.	Iran	359	5.1	51.4
5.	China (Taiwan)	308	4.3	55.7
6.	Thailand	307	4.3	60.0
7.	Pakistan	292	4.1	64.1
8.	China (Mainland)	235	3.3	67.4
9.	United Kingdom	103	1.5	68.9
10.	Canada	95	1.3	70.2
	All Other Countries	2,114	29.8	100
	Total	7,097	100	100

Source: Adapted from "The Changing Role of the Foreign Medical Graduate in the Practice of Medicine in the U.S."; p. 18.
ECFMG: 1981.

9. ISSUE: Do the majority of exchange visitor FMGs return home, or do they ultimately reside in the U.S. permanently?

FINDINGS:

- Data specific to exchange visitor FMGs are usually lacking.

- In assessing return home rate, it is important to differentiate among the various types of exchange visitor programs for FMGs. For example, FMGs sponsored by the Pan American Health Organization (PAHO) are, in the vast majority of cases, in the U.S. less than one year and invariably return home. (See Attachment 9-A.)

- Residency programs can have an impressive track record in terms of the ratio of returning home exchange visitor FMGs, if emphasis is given to this factor. (See Attachment 9-B.)

- There is evidence that the vast majority of exchange visitor FMGs receiving training in public health have returned to work in their home countries. (See Attachment 9-C.)

- For exchange visitors in the area of biomedical research for one specific program (i.e., the NIH International Research Fellowship Program), there is evidence that a majority return home and assume, at least in part, roles for which they have been trained. (See Attachments 9-D and 9-E.) Separate breakout data for physicians are not available.

- Exchange visitor FMGs who are ECFMG-sponsored cannot seek a waiver of the two year return home requirement on the basis of "No objection by home country" (see p. 49 for explanation and Attachment 9-F for data). Furthermore, as a matter of policy, NIH will not endorse an application for a waiver on the basis of "No objection by home country" for any exchange visitor which it sponsors.

ATTACHMENT 9-A

EXCHANGE VISITOR PHYSICIANS
SPONSORED BY THE
PAN AMERICAN HEALTH ORGANIZATION*

Country	1975 Number of Exchange Visitor Physicians in Programs of: Less Than One Academic Year	1975 Number of Exchange Visitor Physicians in Programs of: More Than One Academic Year	1981 Number of Exchange Visitor Physicians in Programs of: Less Than One Academic Year	1981 Number of Exchange Visitor Physicians in Programs of: More Than One Academic Year
Afghanistan	1	-	-	-
Algeria	2	-	-	-
Argentina	5	-	5	-
Australia	1	-	1	-
Bangladesh	1	-	-	-
Belguim	1	-	-	-
Belize	-	-	1	-
Bolivia	-	-	1	1
Brazil	7	2	9	-
Burma	-	-	2	-
Canada	2	-	1	-
Chile	10	-	6	-
China (Mainland)	-	-	35	-
Colombia	2	1	5	-
Costa Rica	1	-	1	-
Cuba	-	-	3	-
Czechoslovakia	1	-	-	-
Dominican Republic	1	-	-	-
Ecuador	1	-	5	-
Egypt	6	-	5	-
Ethiopia	-	-	1	-
Fed. Rep. of Germany	1	-	-	-
French Guiana	2	-	-	-
French Polynesia	1	-	-	-
France	1	-	1	-
Ghana	-	-	3	-
Haiti	-	-	1	-
Hong Kong	1	-	1	-
India	6	-	14	-
Indonesia	4	-	14	-
Iran	5	-	-	-
Iraq	4	-	-	-
Ireland	3	-	1	-
Israel	5	-	7	-
Jamacia	-	-	3	-
Japan	2		3	-
Jordan	-	-	1	-

* Source: Division of Human Resources and Research; Pan American Health Organization, October, 19, 1982.

ATTACHMENT 9-A (Cont.)

Country	1975 Number of Exchange Visitor Physicians in Programs of: Less Than One Academic Year	1975 Number of Exchange Visitor Physicians in Programs of: More Than One Academic Year	1981 Number of Exchange Visitor Physicians in Programs of: Less Than One Academic Year	1981 Number of Exchange Visitor Physicians in Programs of: More Than One Academic Year
Korea	-	-	2	-
Lebanon	-	-	3	-
Malaysia	7	-	4	1
Mexico	5	1	5	-
Nepal	-	-	4	-
Netherlands	1	-	-	-
New Hebrides	1		-	-
New Zealand	-	-	1	-
Nigeria	4	-	-	-
Panama	-	-	1	-
Pakistan	2	-	12	-
Philippines	13	-	8	-
St. Vincent	-	-	1	-
Sierra Leone			1	-
Singapore	4	-	1	-
South Africa	-	-	1	-
Sri Lanka	6	-	7	1
Sudan	-	-	5	-
Suriname	1	1	1	-
Sweden	-	-	1	-
Switzerland	1	-	-	-
Thailand	2	1	10	-
Tokelau	-	-	1	-
Trindidad and Tabagu	-	-	1	-
Trust Terr. of the Pac	1	-	-	-
Uganda	3	-	-	-
United Kingdom	1	-	1	-
USSR	1	-	-	-
Tonga	-	1	-	-
Venezuela	2	-	5	-
Total	132	7	206	3

ATTACHMENT 9-B

EXAMPLE OF A CLINICAL TRAINING PROGRAM EMPHASIZING RETURN TO HOME COUNTRY: THE LATIN AMERICAN TRAINING PROGRAM OF THE DEPARTMENT OF INTERNAL MEDICINE OF THE UNIVERSITY OF MIAMI, SCHOOL OF MEDICINE

The Department of Internal Medicine of the University of Miami, School of Medicine provides an excellent example of a physician exchange program which is sensitive to the underlying purpose of all exchange visitor programs: to enhance mutual understanding between the U.S. and other nations through educational exchange.

The Department has Latin American Training Programs in three areas: Internal Medicine and Medical Subspecialties; a Latin American Medical Faculty Program; and a Latin American Medical Student Program.

Of 110 alien physicians participating in the Internal Medicine and Medical Subspecialties program since 1973, at least 90% have returned to their home countries.* It is the impression that most are in leadership roles in their respective medical communities. Follow-up studies on these FMGs are still in a preliminary stage.

The brochure and descriptive information on the Latin American Training Program in Internal Medicine and Medical Subspecialties emphasize that the candidate from Latin America must intend to return home. The materials also state that it is hoped that the physician will assume a role in medical education upon return to his or her home country.

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* Telecommunication, September, 1982 with William J. Harrington, M.D., Distinguished University Professor, Department of Medicine, University of Miami, School of Medicine.

ATTACHMENT 9-C

RETURN HOME STATUS OF EXCHANGE VISITOR
FMGs RECEIVING DEGREES* FROM THE JOHNS HOPKINS UNIVERSITY,
SCHOOL OF HYGIENE AND PUBLIC HEALTH
ANNUAL DATA FOR 1970, 1975, & 1980

Year of Graduation	Number of Exchange Visitor FMGs	Number of Countries Represented	Number of Exchange Visitor FMGs Returning Home a/	Percent Returning Home
1970	24	17	22	92%
1975	15	11	14	93%
1980	16 b/	13	11	85% (11/13)

a/ Includes two individuals for 1970 cohort and one each for 1975 and 1980 who are working for an international agency. The career of international health workers often involves work in their own country, service to their country working for international agencies, and occasionally periodic return to the U.S. for further study or work.

b/ At least three of these sixteen individuals are still involved in advanced study.

* e.g., Master of Public Health (M.P.H.), Doctor of Public Health (Dr. P.H.), Doctor of Science (Sc.D.), Doctor of Philosophy (Ph.D.), etc. Data do not include exchange visitor FMGs in non-degree programs.

Source: Johns Hopkins University, School of Hygiene and Public Health, September, 1982.

ATTACHMENT 9-D

MIGRATION PATTERNS, BY GEOGRAPHIC REGION*

Region	Known Fellows	In Home Country	In Region/ Out of Home Country	Out of Region
Europe	537 (60%)**	514 (96%)	3***	20***
SE Asia	262 (80%)	231 (88%)	1	30
Latin America	201 (74%)	150 (75%)	7	44
Middle East	64 (82%)	63 (98%)	0	1
Africa	NA	NA	NA	NA
Totals	1,064 (66%)	958 (90%)	11	95

NA = Information not available.

*Separate breakout data for physicians are not available.

**Percentage of the total number of fellows for that region: i.e., Known/Total x 100%. See also Table 10-E.

***By way of illustration, in the case of Europe, 23 of the known fellows have left their home countries. Twenty (20) have left the European region.

Source: Adapted from National Institutes of Health International Research Fellowship Program, An Evaluation: 1958-1977, p. 11. NIH Publication No. 80-2096 July 1980.

EXPIRATION OF EXCHANCE
VISITOR STATUS

Section 212(e) of the Immigration and Nationality Act, as amended, specifies a two-year home country residence requirement before the exchange visitor is eligible to transfer to another temporary visa category or permanent residence. This requirement means that the former exchange visitor must be physically present in the country of nationality (or last permanent residence) for an aggregate of at least two years following departure from the U.S.

Exchange visitors subject to this two-year home country residence requirement are those: (1) financed, in whole or in part, by the U.S. Government or by their own governments; (2) nationals or residents of countries in which their specialized skills are needed as determined by the USIA; or (3) FMGs who acquired exchange visitor status for the purpose of receiving accredited graduate medical education (i.e., exchange visitors under ECFMG sponsorship).

Upon completion of graduate medical education, exchange visitor physicians must return to their home country of nationality (or last foreign residence) for a period of two years unless they receive a waiver of the two-year home country residence requirement.

A waiver of the two-year home country requirement may be granted for any one of the following reasons:

1. "exceptional hardship" to a U.S. citizen or permanent resident, spouse, or child of the exchange visitor which would be caused by his or her departure from the U.S. and residence abroad.

2. "Persecution" because of race, religion or political opinion if he or she is forced to return to the country of last residence or nationality.

3. "Interest of a U.S. Government Agency" This option is available if the granting of the waiver would be in the public interest and the exchange visitor's absence from the U.S. would be clearly detrimental to a program or activity of interest to that agency.

4. "Statement of no objection by home country" Only foreign medical graduates who came to the U.S. or acquired exchange visitor status prior to January 10, 1977, for the purpose of obtaining graduate medical education or training, are eligible to apply for a waiver of the two-year home country residence requirement on the basis of a no objection statement issued by the country of nationality or last residence.

Attachment 9-F provides a summary of waivers for FMGs on J-1 visas. The data cover a two-year period 7/1/80 through 6/30/82.

ATTACHMENT 9-E

CURRENT STATUS OF FELLOWS, BY GEOGRAPHIC REGION

Status	Europe	SE Asia	Latin America	Middle East	Africa*	Total
Academic position	291	138	73	45		547
Nonacademic research	105	62	38	6		211
Science administration	22	5	1	2		30
Hospital; private practice	91	11	18	4		124
Out of country	23	31	51	1		106
Fellowship status	2	12	19	5		38
Deceased	3	3	1	1		8
Unknown	359	65	71	14	43	552
Total Known fellows	537	262	201	64		1,064

*Information not available.

Source: Adapted from National Institutes of Health International Research Fellowship Program, An Evaluation: 1958-1977, p. 11. NIH Publication No. 80-2096, July 1980.

ATTACHMENT 9-F

SUMMARY DATA ON WAIVER OF TWO-YEAR HOME COUNTRY
RESIDENCE REQUIREMENT FOR EXCHANGE VISITOR FMG UNDER ECFMG
SPONSPORSHIP 7/1/80 THROUGH 6/30/82

Type of Waiver	Number Approved
Hardship	85
Persecution	14
Interested Agency	32
No Objection a/	222
Total	353 b/

a/ For FMGs who came to the U.S. for the purpose of obtaining graduate medical education, only those who came to the U.S. or acquired exchange visitor status prior to January 10, 1977, are eligible to apply for a waiver of the two-year home country residence requirement on the basis of a no objection statement issued by his/her country of nationality or last residence.

b/ 48 countries represented.

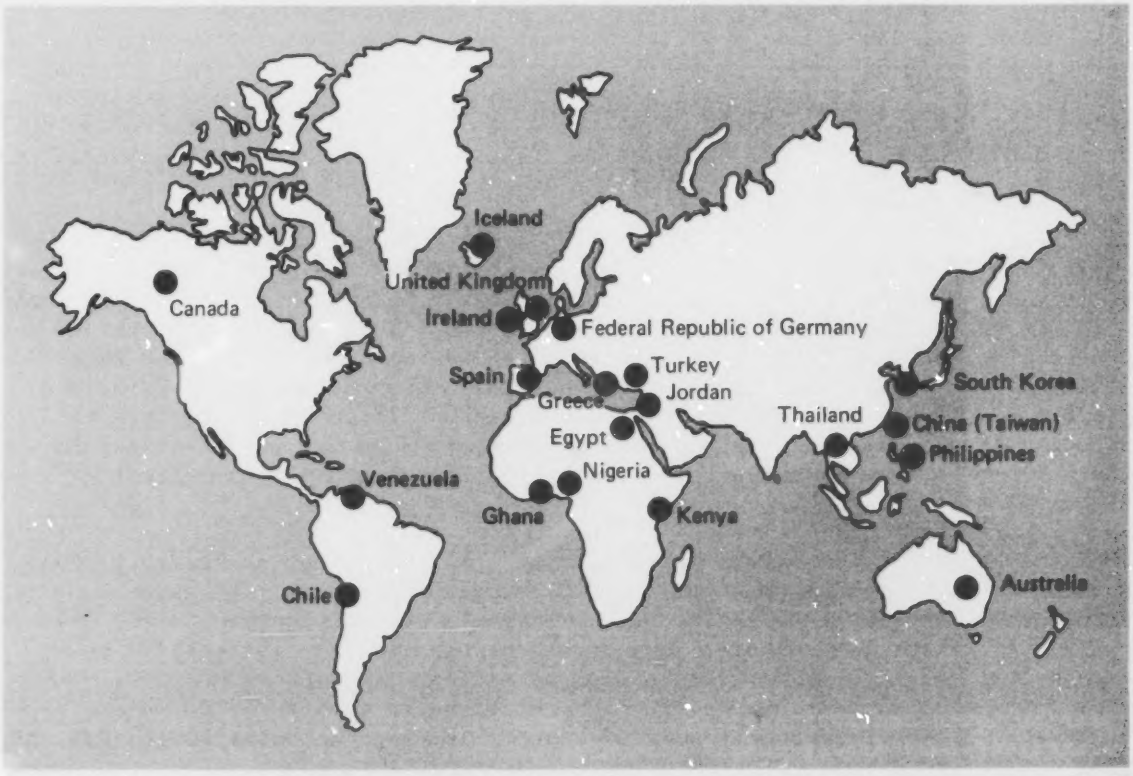
Source: Office of the General Counsel, USIA, September 3, 1982.

10. ISSUE: Of what value are physician exchange visitor programs to the home countries of participating physicians?

FINDINGS:

- Information obtained by the USIA from overseas posts is quite supportive of physician exchange visitor programs.
- The information on the countries which follow was adapted (unless otherwise noted) from information obtained by USIA from overseas posts in these countries.
- Of the 20 countries presented, 18 are drawn from the sample resulting from information assembled from post cables. The sources of information for the remaining two countries (Iceland and Egypt) are provided in footnotes on the respective pages.
- Country data are arranged alphabetically by geographic region, starting with the Near East, then Africa, the Americas, the Far East, and Europe.

Selected Country Data on Value of Physician Exchange Visitor Program



JORDAN

Over the past ten years, 96 Jordanian physicians who participated in graduate medical education programs in the U.S. returned to Jordan, according to Mr. Hisham Kamal, Director, of the Jordan Medical Association . It is mandatory in Jordan that every returning physician register at the Association before being granted a license to practice medicine.

Of the number of returned physicians, 10 percent are engaged in teaching at the University of Jordan and 72 percent are in full-time medical practice. Although no physicians are involved in research alone, 30 percent are of those on the teaching staff at the University of Jordan, and 30 percent are involved in research along with their teaching assignments.

Interviews were conducted with the Minister of Health, Dr. Zuhair Malhas and the President of the Jordan Medical Association, concerning the effectiveness and value to Jordan of medical education programs in the U.S. The Minister of Health had part of his own medical training in the U.S.

As for the value of U.S. medical training, the Minister of Health had the following to say. "The impact of medical training of Jordanian doctors in the USA is great enough and of utmost value to Jordan. Unfortunately, I note the following: increasingly it has been difficult for Jordanians to have post-graduate training in the USA due to the increasing constraints enacted by Congress. Hopefully, this position can be modified. I strongly urge that doors to postgraduate studies in the USA be kept open." He expressed his concern over the fact that this situation is pushing doctors to study in Eastern European countries and Russia.

The President of the Medical Association, who had his postgraduate medical training in Britain highly praised the value of American training for physicians. He added that such training is well respected based upon returning physicians who excelled in their practice in Jordan. He said that these doctors were lucky to have their training in the USA and had excellent placements, since such opportunities in the U.S. are denied applicants now. He also expressed grave concern over the fact that young doctors are forced to get their postgraduate work in Russia and Eastern European countries.

In this regard, he said that doctors trained in Russia do not fit in the medical field in Jordan, while doctors trained in Britain or the USA fit perfectly and handle all situations efficiently. He elaborated by saying that although medical education in Russia is advanced, it is designed to service the Russian needs in their social context and every doctor is trained in a limited field. Their knowledge is not as wide and varied as that of the U.S. trainee's. He was afraid that by 1985, 70 percent of Jordanian doctors will be completing medical studies in Russia and Eastern Europe and he is afraid that they will have to conduct their lectures in Russian at his medical association.

POST'S COMMENTS on the value of graduate medical education in the U.S.: Post would like to emphasize the high regard, respect and credibility which Jordanian doctors trained in the U.S. enjoy. Any doctor trained in the U.S. shines in his practice within a few months of his return. This leaves an impact on the community and the medical standards. As mentioned above, such U.S.-trained physicians are regarded as the standard against which they measure graduates from other countries. This is of great value to the U.S. as well as to Jordan.

TURKEY

Interviews were conducted with officials of the Ministry of Health, Ministry of Education, medical school faculty members and deans, and private physicians. Their comments form the basis of the following report.

In discussions with the Ministry of Health's Director for External Relations (Sevinc Cezikturk) it was learned that the pattern of returning physicians is divided between those who first remain in the U.S. to practice or become more specialized for a few years and those who return immediately to begin their careers, but then often go back to the U.S. for advanced training.

Dr. Cezikturk also noted how great the need was for establishing linkages between Turkish and American medical institutions for the purpose of specialized training.

The Ministry's Secretary General (Islam Kutlay) added that while Turkish physicians are sent each year to such European countries as the United Kingdom, the Federal Republic of Germany, and the Netherlands under the aegis of bilateral technical agreements for training, no such agreement exists with the United States. No substantive programs have been available for Turkish physicians since the winding down of A.I.D.'s role here nearly a decade ago.

Regarding medical school graduates more specifically, our best source of information has been Hacettepe University's Medical School and Hospital in Ankara. Of Turkey's fourteen medical schools (which graduate approximately 2,000 students each year) this is the most prestigious. It alone conducts classes in English, uses standard American texts and applies American teaching methods. Its faculty of about 225 professors and assistant professors, comprising the bulk of the hospital's medical staff, includes 108 U.S.-trained Turkish physicians, nearly half of whom have received this training within the last ten years.

According to Namik Cevik, Assistant Dean of the Medical Faculty for Administrative Affairs, the number of U.S.-trained physicians at Hacettepe is unfortunately diminishing. This is not due to the fact that fewer Turkish medical graduates are returning to Turkey after their U.S. experience, but because fewer have the opportunity to go to America in the first place. Graduating medical students widely perceive difficulties in entering the competitive U.S. physician marketplace, he stated. They have read about the anticipated, and much-publicized "doctor glut", and feel that restrictive measures on the entry of exchange visitor physicians to the U.S. for educational or professional purposes are already being applied.

The Ministry of Health spokesman and Mr. Cevik noted that it is especially discouraging to have so few professors at Hacettepe--eight this year--find opportunities to pursue their medical research work or obtain specialized training in the United States. Without some kind of formal mechanism to expand and facilitate such periodic opportunities, he felt that the few who do go have a built-in incentive to remain.

According to another source at Hacettepe, Dr. Emin Kansu (Doctor of Internal Medicine), who pursued his medical training in the U.S. between 1971 and 1973 and then worked there until 1978 before returning to Turkey, approximately 12 physicians--like himself--have gone to the U.S. each year from Hacettepe Medical School over the past ten years.

Of these, he claims over 60 percent have returned to Hacettepe. Others are elsewhere in Turkey, and a few may have yet to return. If this sampling is a useful index, then one can infer a return rate of 80 percent or higher.

Dr. Kansu noted that one of the impediments to graduate medical education in the U.S. was a new Turkish law (Ministry of Education) which requires recently graduated physicians to render their services to needy, and often remote, regions of Turkey where there is a shortage of doctors and medical facilities. This compulsory service may last for a period of two years and can often interfere with a young physician's career ambitions.

The breakdown on where returning physicans work--in academia, research, or private practice--is impossible to give accurately. The total number of Turkey's physicians is nearly equally divided between the public and private sectors. The public sector is directed almost solely towards the practice and delivery of health care services, with very little research or academic work. The bulk of the private sector is also engaged in practice, but a large proportion of these physicians teach and do research, since affiliation with universities and/or medical centers is vital in building up a private pratice. As a result, U.S.-trained physicians are more likely to return to university/hospital settings which link teaching, research, and private practice.

Ministry of Health officials cited the value of U.S. medical experience and know-how in the development of Turkey's prestigious Haydarpasa Chest Surgery Center in Istanbul, where 15 of the 20 resident physicians have had U.S. training. Similarly, in Ankara, the Embassy physician noted that Gulhane Military Hospital was able to respond quickly and effeciently to heart attacks and other cardiovascular emergencies thanks to a top-notch U.S.-trained Turkish staff.

All those interviewed stressed the importance and value of U.S. training, especially for specialized skills, to the medical profession as a whole in Turkey. Given the fact that such skills cannot be obtained otherwise, the need to augment exchange programs and to facilitate physicians' postgraduate training opportunities in the United States was consistently emphasized.

EGYPT*

In 1975, under a cooperative agreement with the Egyptian Government, Project HOPE was requested to establish a program in Egypt in which HOPE educators would be assigned to develop and implement specialized education programs for Egyptian professionals in the health sciences.

This exchange program provides the opportunity for selected Egyptian medical specialists to visit, study and observe in the United States for periods of one month to two years. It should pointed out that these exchange visitor physicians are not in graduate medical education (i.e. residency) programs. Visits take place in university, hospital and research settings throughout the United States. Evaluation procedures take place upon the Fellow's departure and return to Egypt.

Project HOPE has brought a total of 65 physicians under this exchange visitor program to the United States in the past seven years. All but one of these physicians have returned to Egypt and have continued to pursue their medical and educational careers with distinction. This represents a return home rate of over 98%.

The Fellows chosen to participate in the program are respected professionals in their fields. Selection is made by the Ministry of Health or the Ministry of Education on the basis of leadership potential that can be developed and strengthened with further education. Candidates are examined in English and submit medical records before selection. Upon completion of application procedures, they are interviewed by Project HOPE International Headquarters staff at the most appropriate United States institution.

It appears that these HOPE fellowships in the United States contribute to a health professional's career advancement. Many heads of departments within the colleges of medicine are returned HOPE fellows, as are many heads of divisions of medicine within Egypt's leading public hospitals, administrators of general directorates and directorates within the Ministry of Health, hospital administrators and medical specialists.

The program has been so sucessful that it has been extended for another five years. At the close of that period, it is expected that the program will have successfully completed its objectives and will have done a great deal to foster medical cooperation between the United States and Egypt.

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*Source: Adapted from information provided by the Fellowship Exchange Coordinator, Project HOPE, September, 1982. Sponsorship of the majority of these exchange visitor physicians has been by the U.S. Public Health Service.

GHANA

Due to the severe shortage of medical doctors in Ghana, none may enjoy a career devoted only to research or teaching. All are practicing. Those engaged in teaching or research are also in private practice or working in government hospitals and clinics.

Records are very meager. All officials consulted agreed that effectiveness and value to Ghana of U.S. exchange visitor programs for physicians is of great benefit to the country.

KENYA

The practice of medicine in Kenya continues to have a strong British orientation. American medical education, while greatly admired and respected, seems unduly long and rigorous to Kenyans who begin their medical training immediately upon completion of secondary education.

The regional medical officer stationed here likes the idea of Kenyans receiving medical education in the U.S. which, he maintains, results in much good will and provides tangible evidence that the U.S. system is effective. On the other hand, in a developing country where there is only one physician or dentist per 8,000 inhabitants, there is perhaps, a greater need for basic health services to be provided by paramedics than for sophisticated care which is commonly affordable only by a few.

Highly trained physicians and dentists are, unavoidably, attracted to remunerative private practices rather than to public health delivery systems or the teaching and training of future practitioners. A good argument could be made for our assisting the Kenyans to develop and improve their own teaching facilities and staff so as to upgrade medicine in Kenya rather than educating individual Kenyans abroad.

It may be useful to note that twice-yearly, approximately 100 qualified medical graduates take the ECFMG (Educational Commission for Foreign Medical Graduates) examination administered in Kenya.

In addition, approximately 130 normally sit for the annual VQE (Visa Qualifying Exam). This indication of interest in going to the U.S. for further medical experience is impressive. However, it must be stressed that the great majority (as high as 95 percent) of the examinees are Indian Nationals or Europeans who are resident and practicing medicine in various countries of East Africa.

NIGERIA

While it is known that a majority of government-sponsored trainees return to Nigeria, there is no information on those whose training was sponsored privately. It is thought by a Nigerian former Deputy Director of WHO, that perhaps as many as 25 percent of those sent for medical training abroad may not have returned to Nigeria.

Sources we have sought assistance from included: Medical Statistics Division, Scholarship/Fellowship and External Aid Sections, Ministry of Health; Secretary, Nigerian Medical Council; Provost, College of Medicine, Lagos University Teaching Hospital; Lagos State Ministry of Health; Provost, College of Medicine, Dean, Faculty of Clinical Sciences and Dentistry, Dean, Faculty of Basic Medical Sciences and Pharmacy, and Director, Postgraduate Institute for Medical Research and Training, all at the University of Ibadan; Principal Personnel Officer, University College Hospital, Ibadan; and a Nigerian former Deputy Director of WHO.

The last-named source documented that nine physicians from the Institute of Child Health, Lagos University Teaching Hospital, went to the U.S. for graduate medical studies during the period 1971-81 and all have returned to Nigeria. Two are in teaching, two in research, two are in private and three in government medical practice.

Graduate medical education of Nigerians in the U.S. has been of great value to Nigeria. The effectiveness of training programs and their value to Nigeria could be enhanced considerably by improvement in the selection and predeparture orientation of trainees; the selection of relevant programs and appropriate institutions; and by post-training assessment, and subsequent monitoring of the work of those trained.

CANADA

In Canada, the licensing of physicians is a Provincial, not a Federal, responsibility. It is the duty of each Provincial registrar to satisfy himself concerning the qualifications, training, and suitability of each physician who wishes to practice medicine in that particular Province. There is no central Federal registry of these physicians, nor of the ones who train in the United States or elsewhere. As a consequence, there is no information about the number who have returned to Canada after training in the United States, nor what they are doing.

However, there is some information available concerning Canadian physicians who enter the U.S.A. to continue their medical education or to follow specialized courses. The ECFMG of the U.S.A. requires substantial documentation for each such physician who applies. Health and Welfare of Canada supplies certain information to U.S. authorities before visas are granted. Practically 100% of these physicians return to Canada.

Also of interest, the following information was obtained from Health and Welfare, Canada:

> Active civilian physicians (including those in research, teaching, and administation) in Canada, on December 31, 1980 were grouped as follows:
>
> a) general practitioners and family physicians: 18,853
> b) certificated specialists: 18,434
> c) interns and residents: 6,988
> Total: 44,275

Of groups a) and b), 11,254 (30.2%) were graduates of foreign medical schools.

CHILE

The following questions were answered by Dr. Ricardo Cruz-Coke, Director of the Genetics Department of the Clinical Hospital Jose Joaquin Aguirre of the University of Chile, and Dr. Amador Neghme, President of the National Academy of Medicine and Director of the Institute of Chile. Both concurred in their answers.

Question: How many Chilean doctors who specialized in the U.S. and returned to Chile are dedicated to research, teaching or are practicing medicine in the public or private sector?

Answer: Practically all returnees are working in the different faculties of medicine existing in the country. These medical doctors work as academic researchers and do clinical work in clinical hospitals attached to universities. Of 40 medical doctors surveyed in 1978 (all graduates from U.S. universities), 10 were academics and researchers at faculties of medicine; 2 worked in clinical hospitals and had private practices and 17 worked half-time in clinical hospitals with the rest of their time spent in private clinics.

Question: Do you believe that studies in the U.S. have been valuable to Chilean medical doctors?

Answer: Their studies have had an enormous value. U.S. medicine currently offers the most advanced scientific and technological medicine in the world. Doctors who return to Chile have perfected their professional skills and return as efficient scientists.

Question: What has been the most valuable contribution of U.S. medicine to Chile?

Answer: U.S. medicine has exercised a fundamental influence during the last three decades, changing the structures and functions of Chilean University Hospitals (clinical hospitals). The reforms introduced in these university hospitals with the introduction of higher technologies and the formation of groups of specialists has allowed considerable progress in the quality of medical care and has opened the possibility of clinical research. The contribution has allowed Chilean university doctors to keep level with the accelerated progress of the scientific revolution of present-day medicine.

VENEZUELA

All contacts stressed the importance of training in the United States to upgrade the quality of health care provided in Venezuela. The recent law (i.e., P.L. 97-116) permitting individuals in specialist programs and other medical training to remain in the U.S. for up to seven years was greeted with great enthusiasm here, and leaders in the medical profession made every effort to insure the dissemination of information on the new law and its effects on Venezuelan doctors. Although the medical schools here are gradually beginning to develop more advanced training programs, many specialties are seriously lacking in trained professionals.

Individuals who obtain advanced training in the U.S. generally return to Venezuela to teach and conduct their private practices, thereby insuring the sharing among a large number of interested people of the information and experiences gained.

Many highly influential public figures are doctors. Physicians who received their training in the U.S. are generally among the most talented and active members of their profession. By way of example, the present Accion Democratica presidential candidate (i.e., candidate for President of Venezuela) is a pediatrician by training, and did graduate work at Columbia University.

Continued access to U.S. graduate medical education and training is highly important to the development of Venezuelan medicine and to U.S./Venezuelan relations. Any reduction in access would be viewed as a further indication of U.S. lack of concern for Venezuelan interests.

REPUBLIC OF KOREA

No information is available on the returnee ratio of exchange physicians. However, one Korean Medical Association source estimated the total number of South Korean physicians (including those who have already acquired U.S. citizenship) in the U.S. at 4,500 and returnees at less than one percent. According to another estimate by Dr. Kim Il-Soon, Yonsei University, College of Medicine about 3,000-3,800 Korean physicians went to the U.S. (Mostly during the 1960-75 period.) Many during the sixties and early seventies went as exchange visitor physicians.

There is no estimated breakout of returnees in teaching, research, and practice due the lack of basic data. Most returnees are believed to be with major hospitals in large cities which are affiliated with medical schools. These physicians combine practicing and teaching.

While the large number (estimated) of Korean physicians in the U.S. suggests a drain of physicians, the success of exchange programs is still evident in the fact that many important positions at major medical schools and hospitals in Korea now are occupied by American-trained physicians.

The low returnee rate can be attributed in part to lower Korean living standards and poor medical facilities, especially in the provinces. Returnees sometimes end up in mediocre medical facilities where they cannot practice what they have learned in the U.S.

In the long run, however, the fruit of exchange visitor physician programs will be more in evidence as Korean medical facilities continue to improve and require better trained physicians. This is particularly relevant in view of the fifth economic and social development plan (1982-1986) which emphasizes systematic extension of the National Medical and Social Welfare system.

REPUBLIC OF THE PHILIPPINES

It is impossible to determine the number of Philippine medical graduates pursuing graduate medical education in the U.S. who returned permanently to the Philippines. Queries to the Ministry of Health, the Professional Regulation Commission, the association of private medical colleges and alumni associations of medical schools were to no avail.

The visa section at the consulate does not keep records more than one year, and points out that J-1 visa holders may well go abroad and return home, but later go abroad again on a different kind of visa. The Executive Director of the Philippine Medical Association, Dr. Juan Villasanta, told us there is no government agency and no private sector institution which can furnish this information. The embassy physician concurred.

Dr. Villasanta estimated that three percent of the physicians now in the Philippines may be in other businesses or for other reasons are not practicing medicine.

The Philippine Medical Association encourages members to undertake advanced studies abroad, in order to strength their capability to meet the needs of the country. Dr. Villasanta says many special fields are sparsely manned in the Philippines today, including neurosurgery and cardiovascular surgery. He sees the exchange visitor program as offering the needed learning opportunities and doing its best to assure the return of exchangees to their own country. Embassy staff share this view.

For historical reasons which are still operative, Philippine physicians look first to the United States for advanced medical training opportunities. On their return with their certificates, what these physicians say to colleagues and patients directly or indirectly enhances the image of the U.S. as a world leader in the medical sciences.

CHINA (TAIWAN)

Ten-year data on physicians were not available. However, a five-year survey (1976-1980) showed that of a total 1,166 medical personnel (across several disciplines, including physicians, dentists, and pharmacists) going abroad, 995 studied in the U.S. Only 75 returned from the U.S. to China (Taiwan), giving a 7.5 percent overall return rate. (Source: "An analytical study on numbers of graduates going abroad for study and number of returnees in the fields of science and technology." By Lo Wen-Chi, CEPD, 1982 (Published only in Chinese).

Of the 1,166 medical personnel who studied abroad, in addition to the 995 who went the U.S., 148 went to Japan and a few to Europe; 257 were physicians (48 returned), 139 dentists (5 returned), 396 pharmacists (28 returned), 57 public health specialists (no record of returnees) and 121 "others" (20 returned).

Of interest, the return rate although low overall (7.5 percent), appeared to be highest among physicians (19 percent) as contrasted to other medical personnel.

THAILAND

The effectiveness and value of U.S. exchange visitor programs for medical education was described by the embassy physician, Henry Wilde, as having made "A tremendous contribution to Thai medicine and medical education; one which has been responsible for the fact that Bangkok has become the regional medical center for much of Asia."

Mrs. Chintana Kasemsri, Director of the International Health Division of the Ministry of Public Health, reports that Thai physicians trained in the United States have made a respectable contribution to the practice of medicine in Thailand, especially in the field of tropical medicine.

A publication of the Office of the Prime Minister, entitled "Thailand into the 80's," notes that twenty years ago, patients requiring complex and difficult courses of treatment were sent abroad, but today these treatments can be performed in Thailand and many foreigners are choosing Thai doctors to perform them.

Dr. Anuwat Limcharden, Professor in Medicine at Mahidol University, the most prestigious Medical University in Thailand, praised the value of American medical training for Thai physicians. He estimated that for every five physicians trained abroad, three have been trained in the U.S.; two in England and one in Germany. This ratio, according to Dr. Anuwat Limcharden, reflects the potential impact American medical training can have on the medical profession in Thailand.

AUSTRALIA

It is clear that Australian medical graduates/practitioners view experience in the United States as a valuable part of their professional training and advancement. Australia has traditionally looked to the United Kingdom for advanced medical training and research, but over the last decade the U.S. has been increasingly seen as an alternative.

With restrictions on entry and funding in the United Kingdom, it is likely that the flow of Australians towards the U.S. will continue and probably increase.

There is no doubt that the medical profession in Australia considers experience in the U.S. to be desirable. However, there has been no formal statement to this effect at the government level, but the acceptance of the value of such experience is widely agreed.

FEDERAL REPUBLIC OF GERMANY

German physicians interested in foreign graduate medical education or training may apply to the Federal Ministry of Youth, Family and Health for a supporting certificate indicating the FRG's interest in having Germans receive such education or training and the applicant's intent to return to the FRG following such education or training.

The supporting certificate states: "It is wished that physicians from the FRG be able to deepen their knowledge and skills through qualified activity outside the FRG; it is important that the desired international exchange of experience in the area of medicine can be furthered by means of such measures."

The number of such certificates issued for 1979-1982 by the Federal Ministry of Youth, Family and Health for Germans wishing to pursue graduate medical education or training in the U.S. is listed below:

1979 - 5
1980 - 8
1981 - 18
*1982 - 5

USIA Bonn Exchanges Office and our many USIA field installations in the FRG have a consistently large number of inquiries about opportunities for graduate medical training in the U.S.

The post strongly supports an expansion of U.S. graduate medical opportunities for Germans.

* Number through July 1982.

GREECE

The number of medical returnees from graduate medical education in the United States could not be determined accurately. Official sources, including the Greek State Scholarship Committee, the Fulbright Office, the University Medical Schools, the Ministry of Health, the Ministry of Education, the Bank of Greece, UNESCO, have no verified number to give. This is because many Greek medical students leave the country privately to pursue graduate medical education without going through any of the above mentioned sources.

From conversations with officials, one should assume that only 5-10 percent do not return to Greece, but try to establish themselves in the U.S., Canada, Europe or other countries.

It is generally accepted by all concerned and by the knowledgable public that U.S.-trained medical doctors rank above all other trainees. Presently, the majority of the medical faculty in the country's universities are American trained.

IRELAND

Upon completion of U.S. training, Irish doctors practice as consultants and teach in medical schools. It is generally known that Ireland's best doctors have received training in the U.S.

It has been a tradition for Ireland to send her medical graduates to the United States for training. However, with visa restrictions over the past several years, students are now forced to look to the EEC (European Economic Community) for instruction.

The U.S. is now considered totally lacking in training opportunities for Irish medical graduates according to Professor Patrick Heenan, Dean, Department of Medicine, University College of Dublin, Ireland's largest medical school.

ICELAND*

Even though Icelandic doctors have for more than 100 years finished medical school in Reykjavik (since 1911 at the Medical Faculty of the University of Iceland) and for several decades been able to finish internship in Iceland, they have had to rely entirely on foreign countries for specialty training. The reasons are (1) because of the small population of Iceland, hospital units are too small to give opportunities satisfactory for experience and (2) facilities are incomplete for advanced teaching and research.

Icelandic medical graduates have traditionally sought specialty training in Western Europe and in the United States. Approximately one third of the total number of all Icelandic medical graduates, or 7-8 per year, during the period 1966-1973, started post-graduate training in the United States, and out of the total of 136 medical specialists presently working in hospitals in Reykjavik, 62 were trained in the United States. Most of the U.S. trained specialists have trained in good teaching hospitals and relatively many at the very best institutions. Most of these specialists take active part in teaching and out of 23 clinical teachers with formal appointment at the Medical Faculty of the University of Iceland, 13 were trained in the United States. It is therefore clear that American medicine has had a profound influence on the practice and teaching of medicine in Iceland and in the view of the Icelandic Health Authorities this development has played an important part in the improvement of standards of public health care in Iceland.

It is the view of the Icelandic Health Authorities that severe limitations of possibilities for postgraduate training of Icelandic doctors in the United States will in the future result in a decreasing influence of American medicine in the Icelandic medical community and thereby upset the present balance between American and European ideology and methods for practice of medicine, which would be a most unfortunate development.

Young Icelandic doctors have shown the same interest in postgraduate training in the United States as has been evident in the last decades. (Nearly all graduates take the ECFMG examination and the results have been excellent, as on the average over 95 percent pass on the first trial.)

In view of the above and the excellent traditional relations between the United States and Iceland, it is the hope of the Icelandic Government that a solution can be found, enabling Icelandic medical graduates to continue to benefit from the highly advanced sources of knowledge in medical sciences in the United States.

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*Source: Excerpted from transmittal to the Department of State from the Embassy of Iceland, October 12, 1977. Underlining added for highlighting; not present in transmittal.

SPAIN

The U.S.-Spain Joint Committee for Scientific and Technological Cooperation could obtain statistics for 139 physicians who had studied in the United States during the last ten years. They report that, of the 139, approximately 105 have returned to Spain. They specify that records do not indicate whether these returnees are still in Spain. It is therefore possible that some could have gone back to the United States by now. The embassy doctor also pointed out that those who have not returned to Spain could very well be planning to return.

Graduate medical education in the U.S. is valuable both for the individual Spanish physician and for Spanish medicine in general. A Spanish physician returning from specialty training in the U.S. can expect to find a good position in the medical hierarchy almost immediately. In a country where more doctors are produced than there are jobs, this professional and financial security is especially important.

The professional discipline imparted by U.S. training tends to endure and has a salutory effect on the physician's colleagues, patients and students. It was a U.S. trained neurologist who was asked to head the national team effort to discover the best treatment for the "toxic oil" syndrome this past year.

The U.S. stands to gain as well by the infusion of Spanish interns, residents and fellows. These young men and women are bright and generally very eager for the clinical and technical experience that they lack. Their fluency in Spanish is certainly advantageous in many parts of the U.S. these days, and they can assist their American counterparts in learning the Spanish language and culture which are a part of the heritage of many American patients.

The recent news announcing the discovery of cancer producing genes by a team of young Spanish scientists working at NIH shows that the cooperation between Spain and the U.S. can be beneficial not only for our two countries but for mankind as a whole.

UNITED KINGDOM

The U.K. Department of Health and Social Security (DHSS) estimate over the period 1971-79 was that 70 percent of physicians pursuing U. S. graduate medical education returned to the U.K. Data suggest that a higher proportion are returning in recent years. Before leaving the country, graduates are required to file written assurance with the government of their intention to return on completion of training. Few depart for the United States without guarantee of employment on return.

A breakdown of type of employment on return was not available without a detailed computer search by DHSS.

Medical exchange was felt to be of great value. Dr. Scott Campbell, International Health Division, DHSS, reported: "Graduates value very highly the opportunities for study afforded them by the various centers of excellence in the U.S. and would consider any measure to curtail this aspect of medical training to have decidedly adverse effects on the completeness of their experience and the research collaboration between our two countries."

11. ISSUE: What have exchange visitor programs for foreign medical graduates done to contribute to improve health and enhance medical sciences on an international scale?

FINDINGS:

- Over the past four decades, there have been numerous FMGs who pursued medical studies and training in the U.S. and have gone on to distinguished careers in their homelands. Unfortunately for the specific purposes of this study of FMGs exchange visitors, information about the visa status during their stay in the U.S. is in most instances, not available.

- Major contributions to home countries have been made by FMGs who have trained in the United States. By way of illustration in the clinical fields examples are presented in surgery and the surgical subspecialties. (See Attachment 11-A.)

- The contribution of exchange visitor FMGs in areas of medical research has been extensive. Case of Nobel Laureate medical research which benefited from exchange visitor participation is listed in attachment 11-B.

- Exchange visitor FMGs at NIH contribute significantly to ongoing biomedical research activities (see page 81) . Selected country data for these exchange visitors is provided in Attachment 11-G. New entrant exchange visitor FMG data for NIH are provided in attachment 11-H.

- Foreign medical graduates studying public health in the United States, many of whom came under the exchange visitor program, or similar precursor programs, have made major contributions to their own countries. As exemplified by the case histories in attachments 11-C and 11-D, many graduates assume positions of leadership on return to their home countries.

- Foreign medical graduates who have trained in the U.S. often contribute to health efforts on a worldwide scale via service to international health organizations. (See Attachment 11-F.)

- Foreign medical graduates who trained in public health in the U.S. have made contribution's to their countries in fields other than health alone. (See Attachment 11-F.)

ATTACHMENT 11-A

EXAMPLES OF FMGs WHO RECEIVED SURGICAL TRAINING IN THE U.S. AND RETURNED TO CONTRIBUTE TO THE IMPROVEMENT OF MEDICAL CARE IN THEIR HOME COUNTRY*

- Jose Felix Patino of Bogota, Colombia, did his medical and his postgraduate surgical training at Yale. He has served as Chancellor of the Universidad Nacional, as Minister of Health, and for ten years as the Executive Secretary of the Pan American Federation of Associations of Medical Schools (PAFAMS). He has had a tremendous impact on Latin American medicine.

- Andres A. Santas of Buenos Airies, Argentina, an Honorary Fellow of the American College of Surgeons, benefited from a Rockefeller Foundation Fellowship in the United States, has served as Chancellor of the University of Buenos Aires, and is currently Vice Minister of Health.

- Leopoldo Lopez of Caracas, Venezuela, who has had an important influence in Venezuelan surgery, graduated from Columbia University in 1933. He has been a Governor of the American College of Surgeons.

- Luis Ayala, received much of his surgical postgraduate training in Boston. He is currently the President of the Venezuelan Chapter of the American College of Surgeons.

- Leonel Villavicencio of Mexico City had postgraduate surgical training at the Peter Bent Brigham Hospital in Boston and now is an outstanding vascular surgeon at home. He has played an important role in introducing voluntary hospital accreditation throughout Latin America.

- Gaspar Garcia de Paredes, the present Minister of Health of Panama, had graduate training in surgery in the United States.

- Julio Wong is Professor of Surgery at Panama. He is a graduate of Johns Hopkins and had his surgical training at St. Louis University.

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* Source: Adapted from information provided by Joseph P. Evans, M.D., Consultant to the American College of Surgeons. September, 17, 1982. The actual visa status for these FMGs was not available.

- E. Latunde Odeku, (now deceased) received his neurosurgical training at the University of Michigan, established neurological surgery at Ibadan in Nigeria and went on to be Dean of the School.

- Fernando Cabieses, one of the leading neurological surgeons in Lima, Peru, received graduate training at George Washington University.

- Keiji Sano, received part of his training at the University of California. He is now an outstanding Japanese neurological surgeon, was made an Honorary Fellow of the American College of Surgeons last year, and is Chairman of Neurologocial Surgery at the University of Tokyo.

- Shozo Ishii of Juntendo University, Tokyo, has one of the outstanding neurosurgical units in the world from the standpoint of training facilities. He spent four years in the neurosurgical laboratories at the University of Chicago.

- Charas Suwanwela is head of the Neurological Institute in Bangkok, Thailand. He spent fourteen months in the neurosurgical laboratories at the University of Chicago and completed his neurological surgical training at Winston-Salem. He was the first Royal Thai Fellow to be sent to the United States.

ATTACHMENT 11-B

EXAMPLE OF NOBEL LAUREATE BIOMEDICAL RESEARCH IN THE U.S. WHICH BENEFITED FROM EXCHANGE VISITOR PHYSICIAN PARTICIPATION

Dr. D. Carleton Gajdusek of the United States received the Nobel Prize in 1976 for work on atypical slow viruses. During his many years of work leading to the Nobel prize, Dr. Gajdusek collaborated with two physician scientists, who periodically returned to his NIH laboratory under exchange visitor sponsorship.

Dr. Vincent Zigas of Australia has returned to the NIH several times over the last two decades to bring to the studies the benefits of his field observations on Kuru in New Guinea. Dr. Michael Alpers, also of Australia, has returned to NIH as a Visiting Associate and a Visiting Scientist to work with Dr. Gajdusek in this study.

Currently Dr. Mario Barragan, a neurologist and neurophysiologist and Dean of Medicine of the San Andres University in La Paz, Bolivia, is a visiting scientist in Dr. Gajdusek's laboratory. Likewise, Dr. Chen-ting Chin, Professor and Chairman of the Department of Pediatrics, Peking Medical College is an exchange visitor working with Dr. Gajdusek and his staff.

Both Dr. Zigas and Dr. Alpers are Australian citizens; Dr. Barragan is Bolivian and Dr. Chin is Chinese. This is a good example of the merit of the Visiting Program which enables a continuing international exchange of scientists, including physicians, and thereby fosters long-term collaborative studies.

Source: Foreign Scientists Assistance Branch, Fogarty International Center, NIH.

ATTACHMENT 11-C

EXAMPLES OF CONTRIBUTIONS TO HOME COUNTRIES OF FMGs WHO TRAINED IN PUBLIC HEALTH IN THE U.S.

- Dr. Sushila Nayar had been Mahatma Gandhi's personal physician before coming to the United States. She studied for a Master's degree (M.P.H.) at Johns Hopkins University School of Public Health and then carried out additional study and research for a Doctor's degree in Public Health also at Hopkins (Dr. P.H., 1952). On her return to India she was the Director of Health in Delhi State. In 1957, she was appointed Minister of Health of India. On leaving government service, she founded a medical school to train doctors to serve the rural poor of India.

- Dr. Michel Lechat* came to the United States, attended the Johns Hopkins University School of Public Health taking the Master's degree in Public Health (M.P.H.) in 1963. He stayed on for three more years to complete his doctorate in Public Health (Dr. P.H.). He then worked for the World Health Organization in Washington and Mexico for six years. After this, he returned to his native Belgium where he is now the full Professor of Epidemiology at Brussels and heads the International Program for Epidemiology. Although it has been stated that staying in the U.S. for multiple years of study drastically decreases the likelihood of a foreign medical graduate returning to his home country, this was not the case with Dr. Lechat.

- Dr. Zohair Sebai born in Mecca, educated in Cairo and Hamburg, came to Hopkins in 1965, where he received his Master of Public Health degree (M.P.H.). He returned to his native Saudi Arabia to carry out public health studies attuned to the problems and conditions in his own country. Dr. Sebai carried out an excellent study in the remote oasis village of Turaba, returned to the U.S. for analysis of his data and write-up of his thesis and the granting of his Dr. P.H. degree. Dr. Sebai then returned to his home country, working with the Ministry of Public Health in health planning. He was then appointed Chairman of the Department of Community Health, University of Riyadh, Saudi Arabia. Dr. Sebai has just produced the first monograph to be published by the Saudi Medical Journal. This monograph deals with community health in Saudi Arabia and represents research work done by Dr. Sebai, his colleagues and medical students from the University of Riyadh. This work can be viewed as an offshoot of appropriate training in the U.S. received by Dr. Sebai as an FMG. He was most recently appointed Dean of the newest medical school in Saudi Arabia in Abha, Asir Province.

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* Graham Greene's novel, "The Burned Out Case" opens with a dedication to Dr. Lechat, who at the time of the writing of the book worked in a leprosarium in the Belgian Congo.

Source: Adapted from information provided by the Johns Hopkins University, School of Hygiene and Public Health, September, 1982. The actual visa status of these FMGs during their stay in the U.S. was not available.

- Dr. Luis Carlos Gonzales, M.P.H. 1947, Dr. P.H. 1948 (both at Hopkins) returned to Venezuela to lead the program for malaria eradication there. He rose to the position of Minister of Health. When he left government service he continued work to improve health in Latin America by working with the Pan American Health Organization.

- Dr. Arnaldo Sampaio, M.P.H. 1948, returned to Portugal where he reorganized the Public Health Laboratory System and served as a leader in the field of virological and bacteriological research. He served as Director of the Portuguese Institute of Hygiene from 1968-72. He was instrumental in developing the health component of Portugal's Plan for Development and was responsible for the major program of improvement of Portugal's Hospital Services. From 1972-78, he was the Director-General of Health of Portugal's Hospital Services. He served as a member of the Executive Committee of WHO and many other international organizations. After 30 years of work to improve health care in his nation, he retired from official duties, but still maintains consulting and teaching work.

- Dr. Abdul Zahir from Afghanistan, earned a B.A. and M.D. from Columbia University. He returned to the U.S. in 1955 to study for his M.P.H. degree at Johns Hopkins and returned to his country and worked his way up to become the Minister of Health. He later became Ambassador to Pakistan and Germany. Physicians from countries where medicine offers one of the few opportunities to obtain higher education, not only serve as physicians but occasionally occupy high political positions as well. There has been no contact between Hopkins School of Public Health and Dr. Zahir since the Russian invasion of Afghanistan.

- Dr. John Brotherston, Dr. P.H. 1953, was appointed as Professor of Epidemiology at Edinburgh when he returned to his native Scotland. He also served as Dean of the School of Medicine and Director of the Health Services of Scotland. He was knighted in recognition of his contributions to the improvement of health in Scotland.

- Dr. Volvick Joseph studied in the United States and received the M.P.H. in 1975 at Johns Hopkins. Dr. Joseph was recently appointed the Minister of Health of Haiti.

- FMGs from Canada have returned to their country after study at Hopkins to serve both at the highest national level and in rural underserved areas. Dr. Marian Webb, M.P.H. 1968, works in the Central Ministry of Health in Ottawa. Dr. William Bavington, M.P.H. 1974, serves his country in the remote villages and towns of Newfoundland as a member of the rural health services system there. Dr. Chester B. Stewart, another Canadian, M.P.H., Dr. P.H. was Professor of Preventive Medicine, Dean of the Medical School and Vice President for Medical Affairs, at Dalhousie University, Nova Scotia.

ATTACHMENT 11-D

EXAMPLES OF CONTRIBUTIONS TO HEALTH EFFORTS ON AN INTERNATIONAL LEVEL FROM FMGs WHO TRAINED IN PUBLIC HEALTH IN THE U.S.*

- Many of the foreign medical graduates who have attended the School of Public Health at Johns Hopkins have served their own countries in an indirect manner and furthered health efforts on a worldwide scale by service with the World Health Organization (WHO). Examples include Dr. Marcolino Candau, M.P.H. 1941, who was the past Director-General of WHO; Dr. Francisco Dy, M.P.H. 1942, who was the past Director-General of the Western Pacific Region of WHO; Dr. Leo Kaprio, M.P.H. 1948, from Finland, who is the current Director of the European Region of WHO. Dr. Abraham Horwitz, M.P.H. 1944, from Chile, was the past Director-General of The Pan American Health Organization and American Region of WHO. Thus, many of the FMGs who have studied in the United States serve their countries indirectly by serving in the highest regional positions or highest worldwide positions.

- In addition to these Directors-General, there are well over 30 foreign medical graduates who have trained in the United States at the Hopkins School of Public Health who serve in other responsible positions in either central or regional offices of WHO.

- Other examples of foreign medical graduates serving in international agencies include Dr. Annik Rouillon, M.P.H., 1963, who is now the Executive Director of the International Union against Tuberculosis located in Paris, and Dr. Mafis Sadik, from Pakistan, who attended the special Hopkins Health Planners Course, and is now Acting Chief, Project Director, United Nations Development Program.

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*Of historical note, the first class graduated from the Johns Hopkins University, School of Hygiene and Public Health (the first such School in the world) consisted of four students. Two of the four were U.S. citizens, two were Brazilians. One Brazilian returned to his country to become the first Dean of the School of Public Health in Sao Paulo and later to be one of the two physicians credited with founding The World Health Organization at the close of World War II. The second Brazilian graduate was a distinguished medical researcher in Brazil, and also become a subsequent Dean of the School of Public Health in Sao Paulo.

Source: Adapted from information provided by the Johns Hopkins University School of Hygiene and Public Health, September, 1982. The actual visa status of these FMGs during their stay in the U.S. was not available.

ATTACHMENT 11-E

EXCHANGE VISITOR FMG PROGRAMS AT NIH

The NIH is the principal medical research arm of the Federal Government. NIH's mission is to improve the health of the nation by increasing our understanding of the processes underlying human health and by acquiring new knowledge to help prevent, detect, diagnose, and treat disease.

The programs of the categorical Institutes are designed to obtain new knowledge to combat the major killing and disabling diseases prevalent in the United States. Nearly all of the Institutes maintain their own laboratory and clinical research programs. Well over 2,600 research programs are in progress at all times. A principal resource for these studies is the Clinical Center, a research hospital with twice as much space devoted to laboratories as to patient care. The Clinical Center does not offer general diagnostic and treatment services. Patients are selected solely because they have an illness or disease which is under study by one or more of the Institutes.

When the Institutes invite medical scientists to participate in the various exchange programs at Bethesda, the nonimmigrant foreign medical graduates (FMGs) generally fall into two categories:

1) Scientists invited for research who have no element of patient care responsibilities; or

2) Scientists invited primarily for research, but whose research may involve incidental patient care. These scientists must be approved by the Clinical Center Medical Board and are under the supervision of a senior physician who meets all PHS requirements for patient care. These FMGs do not have final responsibility for patients, nor do they receive credit towards medical specialty board certification.

Other FMGs (e.g. resident aliens) who may qualify for other programs at NIH, such as the Medical Staff Fellow program, must meet the requirements of the Clinical Center's Medical Board which requires ECFMG/VQE certification for these candidates in addition to other qualifications.

ATTACHMENT 11-F

EXAMPLES OF CONTRIBUTIONS TO THEIR COUNTRIES
IN FIELDS OTHER THAN HEALTH FROM FMGs WHO
PURSUED STUDIES IN PUBLIC HEALTH IN THE U.S.

- Dr. S.C. Hsu, M.P.H. 1939, came to JHU from China Mainland where he was on the faculty of the Peking Union Medical College. During his year of study at Hopkins, the Communist government took over in China Mainland. Subsequently, Dr. Hsu went to China (Taiwan) where he worked with the U.S. Taiwanese Joint Commission for Rural Reconstruction. In addition to many successful rural health programs, Dr. Hsu was instrumental in developing the mushroom export business in China (Taiwan). At one time, mushrooms were the third most important source of foreign exchange for China (Taiwan).

- Two Brazilian physicians, Dr. Paulo Antunes, M.P.H. 1942 and Dr. P.H. 1944 and Dr. Hermelino Gusmao, M.P.H. 1953, have both served as Vice-President for Social Infrastructure for the ICOMI Corporation, the largest manganese mining operation in the world. The corporation recently diversified to include other types of mines and agricultural projects. (Mineracoes Brasilerias Reunidas S.A.)

Source: Adapted from information provided by the Johns Hopkins University School of Hygiene and Public Health, September, 1982. The actual visa status of these FMGs during their stay in the U.S. was not available.

ATTACHMENT 11-G

NEW ENTRANT EXCHANGE VISITOR FMGs AT THE NATIONAL INSTITUTES OF HEALTH: SELECTED COUNTRY DATA, 1979 THROUGH 1981

Country	Calendar Year		
	1981	1980	1979
Japan	46	37	34
Italy	21	23	21
China (Mainland*)	13	13	0
France	12	11	5
Federal Republic of Germany	10	3	5
FMGs from all other Countries (number of countries represented)	66 (28)	74 (29)	63 (28)
Total	168	161	128

* In June, 1979, a Protocol for Cooperation in the Science and Technology of Medicine and Public Health was signed between DHHS (then HEW) and the China's Ministry of Public Health.

ATTACHMENT 11-H

NEW ENTRANT EXCHANGE VISITOR FMGs AT NIH
BY CALENDAR YEAR - 1979 THROUGH 1982

Calendar Year	Total Number New Entrants
1979	128
1980	161
1981	168
1982	138

Source: Foreign Scientists Assistance Branch, Fogarty International Center, NIH.

12. ISSUE: Are foreign nations producing numbers of physicians consistent with their needs?

FINDINGS:

- Historical factors and the social, political and economic structures of individual nations strongly influence perceptions of need for various levels of health manpower including physicians.

- The medical education system of a country affects perceptions of "need." For example, the duration of training for physicians, the number of medical students, and the availability/non-availability of graduate medical education opportunities influence national perceptions of physician requirements, in absolute as well as relative terms.

- Thus, for any nation, the appropriate ratio of physicians to population as well as physician manpower requirements by specialty area are complex issues.*

- Several foreign nations continue to have significant emigration of highly trained professionals, including physicians.

- There will always exist strong "push/pull" factors influencing physician migration among nations, irrespective of the existence of nationally recognized shortages, surpluses or balances of physician manpower in individual nations. (Sources listed on next page.)

- Migrants, including physicians, move for many possible reasons, including political and religious persecution, the seeking of knowledge, or in anticipation of employment opportunities.

- As has been noted in a 1982 report by Goldstein and Gellhorn: "because of their highly visible position in society, physicians frequently became targets of repressive measures and abuses." The role of repression in influencing fluctuating patterns of physician migration should not be overlooked.

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*It should be noted that these issues continue to be debated in the United States.

- o There is evidence that in a few countries, medical graduates are consciously, but not necessarily expressly, being produced for the international market. The demand for higher education for the children of an expanding middle class produces extraordinary pressure for expanding professional educational opportunities of all sorts including medicine. Ironicallly, there may exist simultaneously an awareness of limited economic opportunity for absorption of the increased medical manpower into the nation's economy.

Sources: Gish, O. and Godfrey, M., "A Reappraisal of the 'Brain Drain'--with Special Reference to the Medical Profession ", Social Science and Medicine, 13C (1979), 1-11.

Goldstein, R. and Gellhorn, A., Human Rights and the Medical Profession in Uruguay Since 1972, p. 13. American Association for the Advancement of Science, August, 1982. AAAS Publication 82-R-4.

Mejia, A., "Health Manpower Migration in the Americas," Health Policy and Education, 2 (1981), 1-31.

Select Commission of Immigration and refugee policy, U.S. Immigration Policy and the National Interest. Washington, D.C., March 1, 1981.

13. ISSUE: Apart from having provided an additional source of physician manpower prior to the provisions of P.L. 94-484, of what benefit are exchange visitor programs for FMGs to the U.S.?

FINDINGS:

- The sharing of our medical education opportunities contributes to good international relations and mutual understanding between the United States and nations around the world, including developing countries.

- There is an interrelationship between exchange visitor programs for FMGs and international relations. (See Attachment 13-A.)

- The following excerpt addresses the value to the U.S. in research activities from the perspective of the National Institutes of Health:

> "International activities, programs, and relationships permit NIH to draw upon worldwide expertise and experience in the furtherance of its biomedical research mission. At the same time, NIH shares its extensive resources with other countries in the global search for new knowledge to address major disease and health problems through research and research training. . . This type of activity involves informal, scientist-to-scientist forms of communication with colleagues in other countries and contributes substantially to the total biomedical research effort."*

- At a personal level, physician exchange visitors are influential interpreters of our society and our way of life when they return to their home countries.

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* National Institutes of Health Annual Report of International Activities, Fiscal Year 1980, p. 1. NIH Publication No. 81-62, June 1981.

ATTACHMENT 13-A

EXAMPLE OF INTERRELATIONSHIP OF PHYSICIAN
EXCHANGE VISITOR PROGRAMS AND INTERNATIONAL RELATIONS

The ECFMG examination center in Cairo was closed in 1964 following several years of negotiations between the Egyptian government, the American Embassy in Cairo, and ECFMG.* The Egyptian government wished to select all persons who would be allowed to take the examination. Furthermore, government officials expected to monitor the center during each examination to make certain that no one other than those they selected actually took the examination.

From the beginning of the ECFMG program, ECFMG policy has required that the application procedure and all phases of candidacy for ECFMG certification be on a one-to-one basis between the applicant and ECFMG, without interference by any third party.

Negotiations between ECFMG and the Egyptian government continued for several years but were abandoned in 1967, when further discussions appeared fruitless. Subsequently, during a time of political turmoil the American Embassy in Cairo closed.

Beginning in 1975, following the re-establishment of a friendly positive relationship between the United States and Egyptian governments, and the reopening of the American Embassy in Cairo, ECFMG received an increasing number of unofficial, semi-official and official inquiries regarding the possible reopening of an examination center in Cairo.

This led to a visit by ECFMG staff to Cairo in September 1977, which was coordinated by the Science and Technology Attache at the American Embassy. Meetings were arranged with the Minister of Health and several of his subordinates, with representatives from the Ministry of Education and with other interested individuals and organizations.

None of the requirements which had been proposed earlier entered into discussions and negotiations. Since July, 1978, the ECFMG Examination and English Test have been administered twice each year in Cairo and the Visa Qualifying Examination annually, both without adverse incident or political difficulty.

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* The Educational Council for Foreign Medical Graduates was officially established in 1956. This organization merged in 1974 with the Commission on Foreign Medical Graduates. The combined organization was officially established as the Educational Commission for Foreign Medical Graduates. Thus, the acronym -- ECFMG -- was retained.

Source: Adapted from information from the ECFMG.

14. ISSUE: Apart from the U.S., what other countries have provided medical education opportunities for physician exchange visitors in recent years?

FINDINGS:

- Historically, during the 1960s and 1970s, the U.S. had offered the widest-ranging and most eagerly sought GME opportunities for exchange physicians.* Over the decade 1972-82, ECFMG has sponsored exchange visitor physicians from over 120 nations worldwide.

- Unfortunately, there was a greater than 50 percent decrease in the number of countries represented by exchange visitor physicians in GME in the U.S. between 1972-73 (109 countries) and 1978-79 (54 countries). (See Attachment 14-A.)

- Information collected from overseas posts for this Report documents the current discouragement and frustration among foreign nations regarding GME opportunities in the U.S.

- Eastern European Countries and the Soviet Union have aggressively pursued medical education exchanges especially with developing nations.** (See Attachment 14-B for an additional citation and selected excerpts.) These exchanges have involved both medical students as well as graduate physicians.

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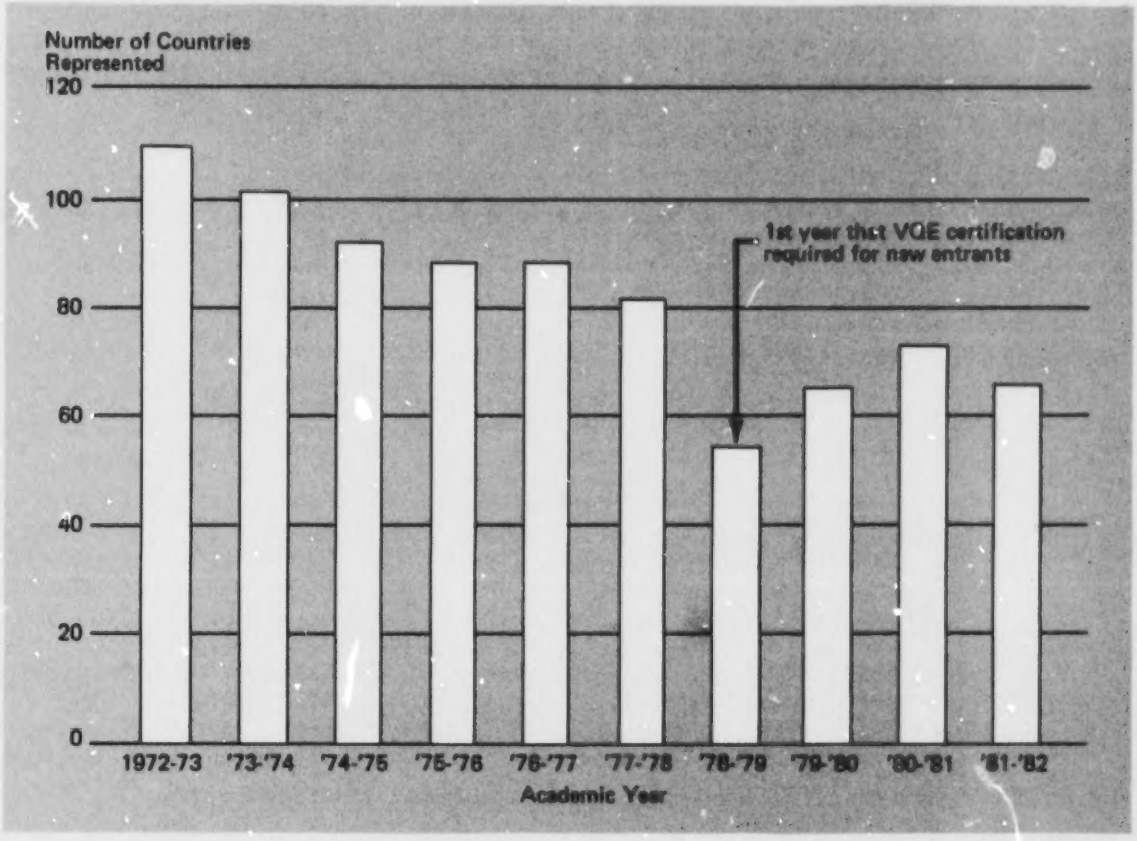
*Travel of physicians from home country to a foreign nation for the purpose of medical education has its roots in antiquity, one example being Hippocrates. During the late nineteenth and early twentieth centuries, medical centers across Europe attracted many Americans who were ultimately to play a prominent role in the development of American medicine, across clinical fields, public health, medical research and medical education.

**U.S. Immigration Policy and the National Interest, p.221. March 1, 1981. Final Report and Recommendations of the Select Commission on Immigration and Refugee Policy (Theodore M. Hesburgh, Chairman). Submitted to the Congress and the President of the United States pursuant to Public Law 95-412. GPO: 1981-0-338-700/8133.10

ATTACHMENT 14-A

Number of Countries Represented by ECFMG-Sponsored Exchange Visitor FMGs, 1972-1982



SOURCE: Educational Commission for Foreign Medical Graduates, September, 1982.

ATTACHMENT 14-B

CITATIONS AND EXCERPTS REGARDING MEDICAL EDUCATION
OPPORTUNITIES IN NATIONS OTHER THAN THE U.S.

- Findings of the Select Commission on Immigration and Refugee Policy (Theodore M. Hesburgh, Chairman). U.S. Immigration Policy and the National Interest, p. 221:

  "Commission research found that many doctors from Latin America, as well as other areas, who fomerly sought to train here, are going elsewhere for their residencies, especially to Eastern Europe and the Soviet Union."

- Evans, J.P. Restoring America's role in international graduate medical education. N Engl J Med, 304: 1542-3, 1981.

  "Our legislation has created an educational vacuum into which other countries have stepped. Many young people have gone elsewhere for their training. Although medical education should be apolitical, the fact remains that we live in an age of overt confrontation. We in the field of medicine are inevitably drawn into the maelstrom. FMGs have gone not only to countries that share the views of the United States but also to many of the Eastern Bloc nations. At present, 160 Panamanians on full scholarships are studying medicine at the undergraduate level in the Soviet Union and its satellite countries. One of my Panamanian correspondents writes,

  '. . . ominously enough, we are seeing a sharp and sudden rise in graduates of socialist countries of Eastern Europe, principally the Socialist and People's University of Moscow (once the Patrice Lumumba University), which welcomes students (who we are sure are seldom selected solely on the basis of academic scholarship) with full scholarships, waiver of tuition, and a stipend to cover living expenses ... part of a long-range program not limited solely to the medical field.'

  "To the best of my knowledge, the same is true of some 50 Ecuadoreans. The figures for Peru are difficult to ascertain with accuracy, but they are considered substantial. Since physicians are often among the best-educated citizens in these countries, many of them, one may presume, will eventually assume positions of considerable political power and will be able to influence decisions of international import."

  "The need of most Latin American countries to avail themselves of our advanced postgraduate opportunities is paralleled by similar needs in other parts of the world."

ATTACHMENT 14-B
(Selected Excerpts -- continued)

o Grundy, P.H. and Budetti, P.P. The distribution and supply of Cuban medical personnel in third world countries. AJPH, 70: 717-19, 1980.

"Soon after the revolution in Cuba, the government chose to develop the health care delivery system as a model of the benefits to be expected under the leadership of Fidel Castro. Spending nearly 15 percent of their national budget on health care and social welfare delivery, the Cubans have achieved a health status profile comparable to those of more developed countries. Having made major progress at home, the Cubans are eager to export their physician-oriented health care system to developing countries. ...More than 2,000 Cuban health care personnel are presently providing care in third world nations; less than five years ago this number was fewer than 100. Some 1,500 of these are physicians, representing nearly 13 percent of Cuba's 12,000 health service physicians.

...Cuba supplies almost the entire health care delivery system to four small African nations and to South Yemen, on the Arabian peninsula. In the Cape Verde Islands, there are 81 Cuban medical personnel; approximately 44 of the 62 physicians in the country are Cubans. Guinea-Bissau has 55 Cuban medical personnel; at least one-half of the country's physicians are Cubans. In Sao Tome, the 86 Cuban medical personnel include about 80 percent of that country's physicians. Equatorial Guinea has 48 Cuban health professionals, including 26 of the country's 31 physicians.

...In Ethiopia, Cuba's military presence is complemented by the presence of 300 physicians caring for the Ethiopian civilian population. These physicians make up nearly one-half of the physician population in Ethiopia. Since Ethiopia already had a medical school at Addis Ababa and a core of medical professionals, the Cuban approach in Ethiopia has been to form joint teams of health care professionals.

...Even in the very poor African nations, Cuba's approach to health care delivery is very much along the lines of the physician dominated polyclinic model....At first, the entire heath care team--both physicians and ancillary personnel--was comprised of Cubans. More recently, Cuba's policy has been to train native ancillary health personnel. This policy will allow Cuba to focus its efforts on supplying additional physicians to expand the number of clinic sites.

...Because Cuba is a socialist state with strong ties to the Soviet Union, and has openly provided military support to 'national liberation" movements in Africa, many in the United States question the purportedly humanitarian motivation behind Cuba's medical foreign policy. Many of the countries in which Cuban medical personnel are working, however, are clearly in need of such help. Until the United States is ready to share its medical resources on a large scale, many countries of the third world are likely to continue to accept such help from our small southern neighbor."

RECOMMENDATIONS

This Report to Congress offers a significant opportunity for review and possible changes in U.S. physician exchange programs since the statute requiring submission of this report (Section 5(e) of P.L. 97-116) specifies the inclusion of "such recommendations for changes in legislation and regulations as may be appropriate."

As documented in this Report, there are complex, interwoven issues which must be considered in any discussion of physician exchange visitor programs.

This section on recommendations is divided into three components: 1) underlying assumptions; 2) principles/overall strategies; and finally 3) recommendations.

Underlying Assumptions for Development of Recommendations:

- There will continue to be a diversity of physician exchange visitor programs with varied specific objectives (e.g., graduate medical education, medical research, public health, etc.)

- Government Agencies (e.g., USIA, DHHS) interested in physician exchange visitor programs will continue operations with steady-state or diminishing resource levels, including staff as well as operating budget and extramural program funds.

- It is impossible to develop statutory language and regulations which cover every specific situation involving physician exchange visitors. Some flexibility in approach must be maintained to deal with extraordinary circumstances which arise periodically.

- Entry into accredited residency training positions will be increasingly competitive owing to the expansion in the number of graduates of U.S. medical schools along with other factors.

Principles/Overall Strategies in Developing Recommendations:

- International exchange programs continue to be an important policy undertaking by the United States.

- Neither Congress, the Administration nor the American medical profession would be supportive of approaches to enhance physician exchange program which did not foster as a prime objective the return home of participating FMGs.

- Any approach must take into consideration the wide range of medical education and health care delivery needs of the foreign nations represented by exchange visitor physicians.

- Given the complicated interwoven issues surrounding physician exchange visitor programs, there is no single, simple recommendation which can address these. There is the need for a set of recommendations to address the set of issues.

- There will continue to be the need to evaluate the knowledge level of prospective FMG entrants into graduate medical education in a manner which is consistent with expectations for graduates of U.S. medical schools.

Specific Recommendations

1. The United States Information Agency (USIA) in cooperation with the Educational Commission for Foreign Medical Graduates (ECFMG) should continue to improve the data base on exchange visitor physicians. Collated data must span across all sponsors.

2. USIA should guarantee that all sponsors of exchange visitor physicians emphasize the return home provisions of the programs.

3. USIA should convene an informal advisory group comprised of individuals from interested private and public organizations at least twice each year. This group will provide expert advice on the development of the annual report (required by statute) on the status of exchange visitor physicians in graduate medical education or training.

4. USIA in cooperation with ECFMG should establish a clearinghouse on current and projected future opportunities for exchange visitor physicians. Such a clearinghouse would foster the underlying purpose of all exchange programs. Furthermore, it would contribute to more realistic expectations abroad regarding the availablility of exchange visitor opportunities in the U.S.

5. Consideration should be given by USIA to providing U.S. support for expanded bilateral medical exchange visitor programs, especially in faculty development. The present Report documents the interest and need across many nations in pursuing physician training opportunities in the U.S. Physician exchange visitor programs can serve as the pathway for enhancement of medical education and subsequent improved medical care for participating nations. An administrative focus for coordinating medical education exchange visits should be established.

6. Based upon the information contained within this Report, physician exchange visitor programs are of value to both home countries as well as the U.S. The U.S. Public Health Service affirms that physician exchange visitor programs contribute to timely acquisition of information on advances from around the world in areas of clinical medicine, public health and medical research and the fostering of attitudes worldwide that the United States is vitally interested in the health and advancement of peoples of all nations.

APPENDIX A

Chronology of Legislation Relating to Alien Physician Exchange Visitors

Surplus Property Act of 1944 (P.L. 78-457), as amended by P.L. 79-584
(Fulbright Amendment, August 1, 1946)

The Surplus Property Act of 1944 (P.L. 78-457, October 3, 1944) established the authority "to aid the reconversion from a war to a peace economy through the distribution of Government surplus property . . . ." In 1946, an amendment to this Act sponsored by Senator William J. Fulbright of Arkansas provided for the use of proceeds from the disposal of property located in other countries for the purpose of supporting educational exchange activities with those countries.

The Fulbright amendment designated the Department of State as the disposal agency for all surplus property outside the continental United States, its Territories and possessions. The Secretary of State was authorized to enter into agreements with foreign governments to use any foreign currencies, credits, substantial benefits, or claim settlements received for surplus property to provide for (a) financing studies, research, instruction, and other educational activities of or for American citizens in schools and institutions of higher learning located in such foreign country, or of the citizens of such foreign country in American schools and institutions of higher learning located outside the continental United States and territories, including payment for transportation, tuition, maintenance, and other expenses incident to scholastic activities, or (b) furnishing transportation for citizens of such foreign country who desire to attend American schools and institutions of higher education located within the United States.

Under the terms of the original Fulbright amendment, funding for educational exchange was limited to expenses incurred in the particular foreign countries where surplus property credits were received. Credits could not be converted into United States currency for use in this country and therefore had to be

spent in the specified foreign countries. For the purpose of selecting students and educational institutions to participate in the educational exchange program, the Fulbright amendment authorized the President to appoint a Board of Foreign Scholarships, consisting of representatives of cultural, educational, student and war veterans' groups, together with representatives of the Office of Education, the Veterans Administration, State educational institutions, and privately endowed educational institutions.

The early Fulbright program provided an endorsement of the idea of international exchange in education, although little money was provided for the study of medicine as such.[1/]

1/ Stevens, Rosemary, and Joan Vermeulen. Foreign Trained Physicians and American Medicine. DHEW Publication No. (NIH) 73-325, June 1972. pp. 50-52.

United States Information and Educational Exchange Act of 1948
(P.L. 80-402, Smith-Mundt Act, January 27, 1948)

The United States Information and Educational Exchange Act of 1948, or "Smith-Mundt Act," had as its objective to promote a better understanding of the United States in other countries and to increase mutual understanding between the people of the United States and the people of other countries by means, among others, of an educational exchange service enabling the United States to cooperate more effectively with other nations in the interchange of persons, knowledge, and skills. The Secretary of State was authorized to provide for interchanges on a reciprocal basis between the United States and other countries of students, trainees, teachers, guest instructors, professors, and leaders in fields of specialized knowledge or skill. Wherever possible, interchanges were to be provided by using the services of existing reputable agencies which are successfully engaged in such activity. Visitors from other countries were to be admitted as "nonimmigrant visitors for business" under the Immigration Act of 1924, as amended, for such time and under such conditions as might be prescribed by regulations promulgated by the Secretary of State and the Attorney General. The Act as originally passed did not place a statutory time limit on a student's stay. Appropriations were authorized as needed, to be used jointly with available foreign currencies to carry out the purposes of the Act. In implementing the interchange program, the Secretary was authorized to make grants of money, services, and materials to individuals, organizations, and agencies both in the United States and in other countries.

This legislation opened the way for significant numbers of alien physicians to enter the United States for graduate medical education (internship and residency training), mainly under nongovernmental programs.[1/]

1/ Ibid., pp. 52-54.

Immigration and Nationality Act of 1952
(P.L. 82-114, June 27, 1952)

The Immigration and Nationality Act of 1952 made major revisions in the law relating to immigration, naturalization, and nationality. As a part of this revision, the Act amended and restructured existing law defining classes of nonimmigrants, including temporary visitors for various purposes. Under new section 101(a)(15) of the Immigration and Nationality Act, two new classes of nonimmigrants were created: students (the so-called F visa) and temporary workers (the so-called H visa).

The student or F visa was for an alien having a residence in a foreign country which he has no intention of abandoning, who is a bona fide student qualified to pursue a full course of study and who seeks to enter the United States temporarily and solely for the purpose of pursuing such a course of study at an established institution of learning or other recognized place of study in the United States, particularly designated by the alien and approved by the Attorney General after consultation with the Office of Education.

The temporary worker or H visa was for an alien having a residence in a foreign country which he has no intention of abandoning (i) who is of distinguished merit and ability and who is coming temporarily to the United States to perform temporary services of an exceptional nature requiring such merit and ability; or (ii) who is coming temporarily to the United States to perform temporary services or labor, if unemployed persons capable of performing such service or labor cannot be found in this country; or (iii) who is coming temporarily to the United States as an industrial trainee.

The former class of nonimmigrants for "temporary visitors for business" was eliminated. Accordingly, the Act amended the Smith-Mundt Act relating to

educational exchange (see above) to make it clear that exchange visitors under that Act would be admitted not as "temporary visitors for business" but rather as nonimmigrants under new section 101(a)(15).

Under this law, alien physicians entered the United States as exchange visitors for graduate medical education under various types of visas, including the H visa and a new J visa that was created administratively for the specific purpose of covering exchange visitors under the Smith-Mundt Act.[1/]

1/ U.S. House of Representatives. Committee on the Judiciary. Report of Subcommittee No. 1 on Immigration Aspects of the International Exchange Program. H. Rept. No. 721, July 17, 1961.

An Act to amend the United States Information and Educational Exchange Act of 1948, as amended
(P.L. 84-555, June 4, 1956)

This Act required a person who is admitted to the United States as an exchange visitor or who acquired exchange visitor status after admission to return, at the expiration of the time for which he was admitted, to his country of origin or to a cooperating country and to reside therein for an aggregate of at least two years before he is eligible to apply for an immigrant visa, or for a nonimmigrant visa under section 101(a)(15)(H) of the Immigration and Nationality Act (H visa exchange visitor), or for adjustment of status to that of an alien lawfully admitted for permanent residence.

The stated object of the new restriction was to make it clear to all concerned that the educational exchange program under the United States Information and Educational Exchange Act of 1948 (Smith-Mundt Act), as amended, was not an immigration program and should not be used to circumvent the operation of the immigration laws.[1/]

A provision of the Act authorized the Attorney General, upon request of an interested Government agency and the recommendation of the Secretary of State, to waive the two-year residence requirement if such waiver is found to be in the public interest.

The new restriction was made applicable only to persons acquiring exchange visitor status subsequent to the date of enactment of this Act.

In 1959, rulings by the State Department limited to five years the time for which an alien physician could be admitted to the United States under the educational exchange program for residency training. However, both this limitation and the

waiver provision under P.L. 84-555 reportedly were loosely enforced, allowing large numbers of foreign medical graduates (FMGs) with exchange visitor status to become full immigrants during this period.[2/]

1/ U.S. Senate. Committee on Foreign Relations. Report to accompany S. 2562, a bill to amend the United States Information and Exchange Act of 1948, as amended. S. Rept. No. 1608, March 1, 1956.

2/ U.S. Department of Health and Human Services Publication No. (HRA) 80-70 September 1980, "Identification of Specific Effects of Title VI (of P.L. 94-484) Restrictions on Selected Hospitals and Implications for Health Manpower." p. 2.

Mutual Educational and Cultural Exchange Act of 1961
(P.L. 87-256, September 21, 1961)

The Mutual Educational and Cultural Exchange Act of 1961, an Act designed to consolidate into an orderly pattern various existing laws (Fulbright amendment, Smith-Mundt Act, and so on) that promoted better mutual understanding among the peoples of the world through educational and cultural exchanges, included several amendments to the immigration laws as related to exchange visitors.

The Act incorporated into the basic immigration law a special nonimmigrant visa --category J--designed to serve solely the purposes of the Mutual Educational and Cultural Exchange Act of 1961. Under existing law, individuals participating in educational exchange programs had been receiving various types of nonimmigrant visas, including the F category and the H category as well as a "J-type" visa issued by administrative arrangement. The new statutory J visa provided nonimmigrant status for "an alien having a residence in a foreign country which he had no intention of abandoning who is a bona fide student, scholar, trainee, teacher, professor, research assistant, specialist, or leader in the field of specialized knowledge or skill, or other person of similar description, who is coming temporarily to the United States as a participant in a program designated by the Secretary of State, for the purpose of teaching, instructing or lecturing, studying, observing, conducting research, consulting, demonstrating special skills, or receiving training, and the alien spouse and minor children of any such alien if accompanying him or following to join him." 1/ Henceforth, the F visa was intended to be reserved for students other than exchange students. The new J visa would be available only to nonimmigrants selected under the exchange program.

1/ New Section 101(a)(15)(J) of Immigration and Nationality Act.

The Act further incorporated into the Immigration and Nationality Act (as Section 212(e)) the provision of P.L. 84-555 (see above) that no person admitted to the United States as an exchange visitor or acquiring such status after admission would be eligible to apply for an immigrant visa, or for permanent residence, or for a nonimmigrant H visa unless such person had resided in the country of his last residence or in another foreign country, for two years. The existing law was amended to require that the two-year residence abroad, if not in the country from which the alien came to the United States, must be in accord with the basic purpose and intent of the exchange program. This modification was designed to avoid situations in which an exchange visitor trained in the United States wished to spend the requisite two years in a country well supplied with the skills he acquired in the United States (e.g., Canada), to the detriment of his own country or other areas where his skills could be better utilized.[2/] The existing authorization for waiver of the two-year requirement by the Attorney General on the request of an interested government agency was amended to allow such waiver also at the request of the Commissioner of Immigration and Naturalization upon his determination that departure from the United States would impose exceptional hardship upon the citizen- or resident alien-spouse or child of the exchange visitor.

2/ U.S. House of Representatives. Committee on Foreign Affairs. H. Rept. No. 1094 to accompany H.R. 8666, August 31, 1961.

Immigration and Nationality Act Amendments of 1965
(P.L. 89-236, October 3, 1965)

The principal purpose of the Immigration and Nationality Act Amendments of 1965 was to repeal the national origin quota provisions of the Immigration and Nationality Act for the allocation of immigrant visas (after a three-year transitional period) and to substitute a new system for the selection of immigrants to the United States. These amendments affecting applicants for immigrant status had indirect significance for FMG nonimmigrant exchange visitors.

Under the previously existing national origin quota provisions, the annual number of immigrants allowed from any quota area in the Eastern Hemisphere had varied according to the number of United States inhabitants in 1920 attributable by national origin to that quota area. In general, birth within a quota area had determined the quota to which an individual was chargeable. Aliens who traced at least 50 percent of their ancestry to persons indigenous to the area known as the Asia-Pacific triangle had been chargeable to appropriate quotas established in that area regardless of their place of birth. This system had tended to favor immigrants from certain European countries from which the bulk of the United States population had been drawn through 1920. Individuals of Asian background, even if citizen of other countries, were at a particular disadvantage. There were no quotas for Western Hemisphere countries under the old law.

The new law provided for an overall numerical ceiling of 170,000 for Eastern Hemisphere immigrants, and an individual foreign state limit of 20,000 for countries in that hemisphere. Within these ceilings, available immigrant visas would be distributed on a first-come, first-served basis according to a new system of seven preference categories which gave primary consideration to family relationships and work skills.

Two of the new preference categories for Eastern Hemisphere immigrants were especially advantageous to FMGs applying for immigrant status: the "third" preference, which made visas available to ". . . qualified immigrants who are members of the professions, or who because of their exceptional ability in the sciences or the arts will substantially benefit prospectively the national economy, cultural interests, or welfare of the United States" and the "sixth" preference, which made visas available to ". . . qualified immigrants who are capable of performing specified skilled or unskilled labor, not of a temporary or seasonal nature, for which a shortage of employable and willing persons exists in the United States."

Individuals entering under the third and sixth preference categories, as well as nonpreference aliens, were subject to labor certification provisions of the Immigration and Nationality Act under which the Secretary of Labor was required to certify to the Secretary of State and the Attorney General that (1) there are not sufficient workers in the United States who are willing, able, qualified, and available to perform such skilled or unskilled labor and (2) that the employment of the alien will not adversely affect the wages and working conditions of workers similarly employed in the United States.

For the first time, an overall limit of 120,000 was placed on Western Hemisphere immigrants. However, no restrictions were placed on the number of immigrants from individual countries in that hemisphere pending the submission by January 15, 1968, of a report to the President and the Congress from a specially created Select Commission on Western Hemisphere Immigration. The only restriction on Western Hemisphere immigrants was that those entering to work must have obtained certification from the Secretary of Labor that their entry would not adversely affect

the American labor market; and this labor certification requirement did not apply to parents, spouses, or children of United States citizens or permanent resident aliens.

The repeal of the national origin quota system together with the new third and sixth preference categories made it easier for certain FMG exchange visitors, particularly those from Asian countries, to change to immigrant status. This applied both to exchange visitors already in the United States and to aliens considering obtaining exchange visitor visas. Although FMGs seeking immigrant visas under the third and sixth preference categories or as nonpreference and Western Hemisphere immigrants still were required to obtain labor certification, the Labor Department ruled in December 1965 that, in view of the general shortage of physicians in the United States, physicians from abroad would automatically receive such certification (under the Department's "Schedule A") without having to apply for it on a case-by-case basis.

Immigration and Nationality Act Amendments--Entry of Nonimmigrants
(P.L. 91-225, April 7, 1970)

P.L. 91-225, Immigration and Nationality Act Amendments--Entry of Nonimmigrants, was enacted in 1970 to facilitate the entry into the United States of certain classes of nonimmigrant aliens and to amend the provisions of law regarding the applicability of the two-year foreign residence requirement for aliens in the United States as exchange visitors.

Under existing law, a person of distinguished merit and ability could, under an H(i) visa, come to the United States for a temporary period to perform temporary services of an exceptional nature requiring such merit and ability in a position. This provision had been interpreted as excluding aliens whose services were required temporarily in positions of a continuing or permanent nature. P.L. 91-225 amended the H(i) visa provision to permit such individuals to perform temporary services, whether the position was temporary or permanent in nature. No change was made in the requirement that the beneficiary must have a residence in a foreign country which he has no intention of abandoning.

The provision of existing law making available an H(iii) visa to an alien having a residence in a foreign country which he has no intention of abandoning and who is coming to the United States as an industrial trainee was amended to delete the word "industrial." Thus, "the class of nonimmigrant described in this clause would not be limited to an industrial trainee and would permit the admission of a trainee in agriculture, commerce, finance, government, transportation, or the professions. This amendment is in accord with existing administrative practice and is merely a clarification of the present law."[1/] As noted above, some FMG exchange visitors had been admitted as "industrial trainees."

P.L. 91-225 made several changes in section 212(e) of the Immigration and Nationality Act, regarding the right of a J visa exchange visitor to adjust his status or obtain an immigrant visa or an H visa unless he had resided for two years in his country or some other country in which two years' residence would fulfill the purpose and intent of the Mutual Educational and Cultural Exchange Act of 1961. The existing foreign residence requirement applied regardless of the financial sponsorship of the exchange visitor (private, United States Government or foreign government) or the needs of the home country for the individual's skills. To conform the requirement to the purposes of the exchange visitor program while at the same time giving due consideration to such problems as the loss of highly skilled persons from less-developed countries, P.L. 91-225 limited the application of the foreign residence requirement to cases where the exchange visitor's participation was financed by the United States or his own government or, regardless of financing, if at the time he acquired J status, the country of which he was a national or resident was one which the Secretary of State had designated as clearly requiring his talents or skills (a listing which, as published in the Federal Register of April 25, 1972, became known as the "skills list").

Section 212(e) further was amended by P.L. 91-225 to eliminate the existing provision that the exchange visitor could fulfill the foreign residence requirement by two years' residence in a foreign country other than that of his nationality or last residence. This provision had proved extremely difficult to administer and had been of marginal utility in terms of the purposes of the exchange programs.[2/]

The amendment of section 212(e) retained the provision of existing law allowing waiver of the foreign residence requirement upon the request of an interested government agency or in case of exceptional hardship upon the alien's spouse or child (if such spouse of child is a citizen of the United States or a lawfully resident alien), and added two additional provisions for waiver: (1) if the alien would be subject to persecution on account of race, religion, or political opinion, or (2) in any case in which the alien's country furnished a statement in writing that it did not object to the waiver. With respect to all of these waivers, the exercise of the authority continued to be at the discretion of the Attorney General if he found the alien's admission to be in the public interest.

1/ U.S. House of Representatives. Committee on the Judiciary. Report to accompany S. 2593, a bill to exclude executive officers and managerial personnel of Western Hemisphere businesses from the numerical limitation of Western Hemisphere immigration. H. Rept. No. 91-851, February 24, 1970.

2/ Ibid.

Health Professions Educational Assistance Act of 1976
(Public Law 94-484, October 12, 1976)

Provisions of the Health Professions Educational Assistance Act of 1976 relating to foreign medical graduates had two main objectives: (1) to assure that alien physicians admitted to the United States as immigrants or exchange visitors were properly qualified to practice their profession in this country; and (2) to tighten the requirements for FMG exchange visitors coming to the United States for graduate medical education such that these individuals would be genuine exchange visitors and would return to their home countries upon the completion of training.

Title VI of the Act amended the Immigration and Nationality Act to provide that, effective January 10, 1977, FMGs wishing to obtain immigrant visas on the basis of their skills under the third preference (members of the professions or persons with exceptional abilities in science or art), the sixth preference (persons who are capable of performing specified skilled or unskilled labor in short supply in the United States) or as non-preference immigrants or certain refugees must have passed Parts I and II of the National Board of Medical Examiners' examination (or an equivalent examination as determined by the Secretary of Health, Education, and Welfare) and be competent in written and oral English.

Also effective January 10, 1977, alien physicians no longer could enter the United States as J visa exchange visitors for the purpose of receiving graduate medical education or training unless: (1) a school of medicine (or other accredited health professions school) and affiliated hospital have agreed in writing to provide the training or to assume responsibility for arranging the provision thereof by an appropriate public or private nonprofit institution or

agency; (2) the individual has passed Parts I and II of the National Board of Medical Examiners' examination (or an equivalent examination as determined by the Secretary), has competency in written and oral English, will be able to adapt to the educational and cultural environment in which he will be receiving his education or training, and has adequate prior education and training to participate in the training program for which he is coming; (3) the individual has made a commitment to return to his country and his country has given written assurance that upon completion of his training he will be appointed to a position in which he will fully utilize the skills acquired in the government or in an educational or other appropriate institution or agency in that country; and (4) the individual will stay no more than two years unless additional training is specifically requested by his country, when a maximum of one additional year of training would be allowed.

Until December 31, 1980, the J visa exchange visitor requirements would not apply if otherwise "there would be a substantial disruption in the health services provided" by the graduate medical education program in which the alien seeks to participate. In administering this waiver provision, the Attorney General was required to take action necessary to ensure that the total number of aliens participating in the graduate medical education programs at any time would not, because of the waiver, exceed the number of such persons participating on the effective date of this provision.

With respect to the use of H visas by nonimmigrant alien physicians, the Act provided that alien physicians no longer would be allowed to enter the United States as persons "of distinguished merit and ability" coming to perform "services of an exceptional nature requiring such merit and ability" (H(1) visa) unless

they have a specific invitation from a public or nonprofit private educational or research entity to teach or conduct research, or both. H visas no longer would be available under any circumstances to aliens coming to the United States to perform temporary services as members of the medical profession (H(ii) visa) or to receive graduate medical education or training (H(iii) visa).

Foreign physicians who were in the United States as exchange visitors and who wished to apply for permanent resident status no longer would be eligible, simply on the basis of written permission from their country, to seek a waiver of the requirement that they first return to their country for a period of two years. One of the other basic conditions for such a waiver would be required to be met: request of an interested Government agency, exceptional hardship to a citizen or permanent resident spouse or child, or threat of persecution in the home country.

In the preamble to P.L. 94-484, the Health Professions Educational Assistance Act of 1976, the Congress declared "that there is no longer an insufficient number of physicians and surgeons in the United States such that there is no further need for affording preference to alien physicians and surgeons in admission to the United States under the Immigration and Nationality Act." On the strength of this finding, the Secretary of Labor on January 18, 1977, removed physicians from the list of occupational groups (Schedule A) for whom labor certification would be automatically approved. Instead, applicants for immigrant status under the third or sixth preferences or as nonpreference immigrants would be required to apply for labor certification on a case-by-case basis. 1/

1/ Under regulations of December 19, 1980, alien physicians again were placed on Schedule A but in this case only if the physicians would be employed in shortage areas for specific medical specialties.

Immigration and National Act Amendments of 1976
(P.L. 94-571, October 20, 1976)

The primary purpose of the Immigration and Nationality Act Amendments of 1976 was to eliminate the inequities in existing law regarding the admission of immigrants from countries in the Western Hemisphere by extending to the Western Hemisphere countries the seven-category preference system (with minor modifications), the 20,000 per country limit, and the provisions for adjustment of status in effect for Eastern Hemisphere countries (see Immigration and Nationality Act Amendments of 1965 above). A numerical restriction of 120,000 immigrants annually for Western Hemisphere countries had gone into effect on July 1, 1968, in accordance with the provisions of P.L. 89-236.

The 1976 Amendments also modified the third preference category to limit it to those members of the professions, scientists, and artists whose services are sought by employers in the United States. Under previous law, members of the professions, scientists, and artists could petition for third preference entry on the basis of their qualifications, without the need for prearranged employment.

To aid colleges and universities in acquiring outstanding educators or faculty members who possess specialized knowledge or unique combinations of skills, P.L. 94-571 further amended the labor certification requirement to require that American workers must be equally qualified for a position in order for certification to be denied in the case of aliens who are members of the teaching profession or who have exceptional ability in the arts or sciences.

These changes in law relating to immigrants affected in various ways the ease with which exchange visitors could convert to immigrant status.

Health Services Extension Act of 1977
(Title III of P.L. 95-83, August 1, 1977)

Title III of the Health Services Extension Act of 1977 made various modifications or amendments in the FMG provisions of the Immigration and Nationality Act as amended by Title VI of P.L. 94-484. The existing law required that before an alien physician could enter the United States as an immigrant (except those with kinship preferences and certain refugees), such person must have passed Parts I and II of the National Board of Medical Examiners' examination (or an equivalent examination) and demonstrated competency in oral and written English. The 1977 Act amended the new requirements to exempt also graduates of medical schools accredited by the Liaison Committee on Medical Education (which include Canadian as well as United States schools) and physicians "who are of national or international renown in the field of medicine."

The existing provisions of the immigration law as amended by P.L. 94-484 required that after January 1, 1977, alien physicians would no longer be allowed to enter the United States as J visa exchange visitors for the purpose of graduate medical education unless (1) a school of medicine (or other accredited health professions school) or affiliated hospital has agreed in writing to provide the graduate training for which the alien is coming to the United States, (2) the individual has passed Part I and II of the National Board of Medical Examiners' examination (or an equivalent examination), (3) the individual has made a commitment to return to his country and his country has given written assurance that upon completion of his training he will be appointed to a position in which he will fully utilize his skills, and (4) the individual will stay no more than two years, with a possible extension of one year. Mainly because of delays in implementing the new examination requirements, the 1977 law postponed the effective date of the provisions to January 10, 1978.

P.L. 95-83 further provided that graduates of medical schools accredited by the Liaison Committee of Medical Education would be exempt from the National Board of Medical Examiners' examination and the English examination requirements. Also, an individual's country would only be required to give written assurance that there is a need in that country for the alien's services, rather than that he will be appointed to a position in which he will fully utilize the skills required.

Under P.L. 94-484, each of the four requirements for entry under the J visa was authorized to be waived for an alien if otherwise "there would be a substantial disruption in the health services provided" by the graduate medical education program in which the alien seeks to participate. P.L. 95-83 provided that only the requirements relating to school affiliation and passage of examinations could be waived; the requirements that the alien make a commitment to return to his home country and that limited the duration of his stay could not be waived.

Because the 1977 Act amended the definition of "graduate of a medical school" in the Immigration and Nationality Act to exclude physicians "who are of national and international renown in the field of medicine," this had the effect of allowing such renowned physicians to be exempt from the H(i) visa requirement (for "persons of distinguished merit and ability") for a specific invitation from an educational or research institution. Also, physicians of national or international renown would remain eligible for the H(ii) visa (for aliens coming to the United States to perform temporary services as members of the medical profession).

To establish a "grandfather clause" for certain alien physicians already in the United States with nonimmigrant status, P.L. 95-83 provided that an alien physician would be considered to have passed Part I and II of the National Board of Medical

Examiners' examination if the alien (1) was on January 9, 1977, a doctor of medicine fully and permanently licensed to practice medicine in a State; (2) held on that date a valid specialty certificate issued by a constituent board of the American Board of Medical Specialties; and (3) was on that date practicing medicine in a State.

Most of these provisions of P.L. 95-83 had the effect of easing for certain alien physicians the requirements for obtaining an exchange visitor visa or for converting from nonimmigrant exchange visitor to immigrant status.

Immigration and Nationality Act--Refugee Policy
(P.L. 95-412, October 5, 1978)

The Immigration and Nationality Act--Refugee Policy amended existing law, which established an annual numerical ceiling of 170,000 for Eastern Hemisphere immigrants and 120,000 for Western Hemisphere immigrants, to provide for a total of 290,000 immigrants without reference to specific numbers for each hemisphere.

Refugee Act of 1980
(P.L. 96-212, March 17, 1980)

The Refugee Act of 1980 amended the Immigration and Nationality Act to decrease the numerical ceiling for immigrants from 290,000 to 270,000 annually.

Health Programs Extension Act of 1980
(P.L. 96-538, December 17, 1980)

The Health Programs Extension Act of 1980 amended the Immigration and Nationality Act to extend for one year, through December 31, 1981, the authority for waiver of certain requirements for FMGs coming to the United States as exchange visitors for the purpose of graduate medical education if the Secretary determines, on a case by case basis, that otherwise there would be a "substantial disruption" in the health services provided by the education program in which the alien seeks to participate.

Immigration and Nationality Act Amendments of 1981
(P.L. 97-116, December 29, 1981)

The Immigration and Nationality Act Amendments of 1981 (P.L. 97-116) further clarified existing requirements for FMG J visa exchange visitors. The Act also liberalized the existing grandfather clause for alien physicians already in this country and established a new category of "special immigrants" to assist certain nonimmigrant exchange visitor FMGs in obtaining immigrant status.

With respect to exchange visitors, P.L. 97-116 changed the length of time that a J visa FMG could stay in the United States for graduate medical education from a maximum of three years to the time typically required to complete such a program, as determined by the Director of the International Communication Agency, based on criteria established in coordination with the Secretary of Health and Human Services and which take into consideration the published requirements of the medical specialty board which administers such education or training program; except that (1) such duration would be limited to seven years unless the alien has demonstrated to the satisfaction of the Director that the country to which the alien will return after completing specialty training has an exceptional need for an individual trained in such specialty, and (2) the alien could, once and within two years of entry as an exchange visitor, receive approval to change the designated program of education or training. This revised length-of-stay provision would be applicable with respect to aliens acquiring exchange visitor status on or after January 10, 1978.

Each J visa FMG henceforth would be required to furnish the Attorney General each year with an affidavit that attests that the alien (i) is in good standing in the program of graduate medical education or training in which the alien is participating, and (ii) will return to the country of his nationality or last

residence upon completion of the education or training for which he came to the United States. This provision would be applicable with respect to aliens acquiring exchange visitor status on or after January 10, 1978.

The Director of the International Communication Agency would be required to report annually to the Congress on aliens who have submitted affidavits, including the name and address of each such alien, the medical education or training program in which the alien is participating, and the status of the alien in the program.

P.L. 97-116 extended through December 31, 1983, the authority for waiver of certain requirements for FMGs coming to the United States as exchange visitors for the purpose of graduate medical education, if the Secretary of Health and Human Services determines, on a case by case basis, that otherwise there would be a "substantial disruption" in the health services provided by the education program in which the alien seeks to participate. The requirements in question are that the FMG pass Parts I and II of the National Board of Medical Examiners' examination or an equivalent examination and that the graduate medical education program in which the FMG participates be provided or arranged for by a medical school. A waiver no longer could be sought with respect to the requirement for competency in English.

In order to receive a waiver, a program of graduate medical education for FMGs would be required to have a comprehensive plan to reduce reliance on alien physicians, which plan the Secretary finds, in accordance with published criteria, to be satisfactory. Such plan must include details relating to (1) problems the program anticipates without the waiver and the alternative resources and methods (including use of physician extenders and other paraprofessionals) that have been and will be applied to reduce disruption in services, (2) changes (including

improvement of educational and medical services training) which have been or will be made to make the program more attractive to graduates of medical schools who are United States citizens, (3) recruiting efforts which have been and will be undertaken to attract graduates of medical schools who are United States citizens, and (4) how the program, on a year-by-year basis, has phased down and will phase down its dependence on foreign medical graduates so that the program will not be dependent upon the admission to the program of any additional such aliens after December 31, 1983.

The Secretary of Health and Human Services, in coordination with the Attorney General and the Director of the International Communication Agency, would be required to (1) monitor the issuance of waivers and the needs of communities with respect to which such waivers are issued, to assure that quality medical care is provided and (2) review each program with a waiver to assure that the required plan to reduce reliance on FMGs is being carried out and that participants in the program are being provided appropriate supervision in their medical education and training.

The Secretary of Health and Human Services, in coordination with the Attorney General and the Director of the International Communication Agency, would be required to report to the Congress at the beginning of fiscal years 1982 and 1983,onthe distribution (by geography, nationality, and medicalspecialty or field of practice) of FMGs in the United States who have received a waiver, including an analysis of the dependence of the various communities on aliens who are in medical education or training programs in the various medical specialties.

J visa FMG exchange visitors coming to the United States in order to receive graduate medical education would be made specifically ineligible for adjustment to another nonimmigrant status without returning to their home country for two years.

Existing authority for suspension of deportation of certain aliens would be amended to make it clear that the authority is inapplicable to an FMG who is a J visa exchange visitor for graduate medical education or training, regardless of whether or not the alien is subject to or has fulfilled the requirement for two years of foreign residence prior to conversion to immigrant status.

The Secretary of Health and Human Services was required, after consultation with the Attorney General, the Secretary of State, and the Director of the International Communication Agency, to evaluate the effectiveness and value to foreign nations and to the United States of exchange programs for the graduate medical education or training of FMGs and to report to the Congress, not later than January 15, 1983, on the evaluation, including recommendations for appropriate changes in legislation and regulations.

The revised grandfather clause under P.L. 97-116 provided that, for the purposes of entry into the United States as immigrants or exchange visitors, foreign medical graduates who were fully and permanently licensed to practice in a State and who were practicing on January 9, 1978, would be considered to have passed Parts I and II of the National Board of Medical Examiners' examination. Such graduates no longer would be required to be Board certified, as was required under the former "grandfather clause" under P.L. 95-83.

The proposed new category of "special immigrant" established by P.L. 97-116 included an immigrant, and his accompanying spouse and children, who has graduated

from a medical school or has qualified to practice medicine in a foreign state, who was fully and permanently licensed and was practicing medicine in a State on January 9, 1978, who entered the United States as a nonimmigrant with an H visa or a J visa before January 10, 1978, and who has been continuously present in the United States in the practice or study of medicine since the date of entry. Because "special immigrants" are not subject to the numerical limitations on the number of aliens from any foreign state who may be admitted to the United States for permanent residence in any fiscal year, this amendment allowed FMGs who meet the above requirements and come from countries with long waiting lists for immigrant visas to receive immigrant visas for themselves and their spouses and children without any further delay. Worldwide numerical limitations and per-country numerical limitations on immigration which are in effect are reduced to the extent that FMGs who adjusted their status under these special immigrant provisions have caused these limitations to be exceeded during the prior year.

APPENDIX B

The Changing Role of the Foreign Medical Graduate in the Practice of Medicine in the U.S.

Revised June, 1981

This report was initially prepared by Thomas D. Dublin, M.D. in his capacity as consultant for research and development to the Educational Commission for Foreign Medical Graduates and was presented to the Commission in May 1980. In its present form the report incorporates more recently available data as well as editorial and other changes. The publication of this report as a monograph, to serve as a background document for an Invitational Conference being convened by the Commission in October 1981, is in keeping with one of the Commission's stated purposes, namely: "to gather, maintain and disseminate data on foreign medical graduates." Such publication should not be construed as an endorsement of the statements, opinions or conclusions expressed therein, for these do not necessarily reflect or constitute the views or policies of the Educational Commission for Foreign Medical Graduates.

FOREWORD

During the past five years, foreign national graduates of foreign medical schools (FMGs) have been affected by the provisions of the sweeping 1976 amendments to the Immigration and Nationality Act. During this same period of time, there has been a sharp increase in the number of United States citizens who have enrolled in medical schools outside this country.

Issues regarding both FMGs and USFMGs were addressed in the 1976 report of the Coordinating Council on Medical Education: *Physician Manpower and Distribution: The Role of the Foreign Medical Graduate* ("CCME Report"). Since then there has not been a comprehensive report addressing the effects of changes from 1976 to the present, or the 1976 CCME statement on the role of the foreign medical graduate.

CCME and its successor, the Council for Medical Affairs (CFMA), and other organizations have expressed interest in data on developments that have taken place since 1976. To assist interested organizations, public bodies and individuals, the Educational Commission for Foreign Medical Graduates welcomed the opportunity to provide Dr. Thomas D. Dublin with much of the data from which he prepared this report.

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INTRODUCTION

THE ENACTMENT of Public Law 94-484, the Health Professions Educational Assistance Act (HPEA) of 1976 and the inclusion of Title VI in that legislation focused nationwide public attention on the increasing role foreign medical graduates (FMGs) have been playing in our domestic health care system. This crystallization of health manpower policy by an Act of Congress invites thoughtful examination, especially from the perspective of the concerns expressed within the medical profession over the preceding two or more decades regarding the causes and effects of this complex phenomenon.

The objectives of Title VI of the HPEA legislation were spelled out in its Section 601 and in the even more exacting language expressing the intent of Congress incorporated in the Report of the Senate Committee on Labor and Public Welfare and the Joint Conference Committee Report of the House and the Senate (1-2). These aims were: to revoke the preferential professional inducements provided in the Immigration and Nationality Act, as amended, which facilitated an almost limitless migration of foreign national physicians to become permanent residents of this country; and, to establish testing criteria providing more rigorous assurances that foreign trained physicians met the same standards of professional competence demonstrated by graduates of domestic (and Canadian) medical schools.

Passage of this Federal legislation has been linked with various studies and reports published within the preceding several years (3-4). Notable among these is the detailed analysis and comprehensive set of recommendations: *Physician Manpower and Distribution: The Role of the Foreign Medical Graduate*, approved initially by the Coordinating Council on Medical Education in September 1974 and subsequently endorsed as a joint statement of policy by each of the Council's five parent organizations (5). That statement offered twelve general recommendations as guidelines to be used in seeking a solution to the overall problem. In addition explicit and detailed recommendations were provided on each of four discrete yet interrelated elements of the foreign medical graduate issue; namely, the foreign national immigrant physician, the foreign national exchange visitor physician, the U.S. national seeking medical education abroad and finally, the role of the United States in international medical education, especially as such education might affect the meeting of health manpower needs of the underdeveloped countries of the world.

In urging concerted nationwide action on its recommendations the Council recognized that the shared interest and joint efforts of many organizations, agencies and institutions were essential to the attainment of the report's objectives. The Council's five sponsoring national professional associations agreed to seek the support of their affiliated or counterpart organizations at state and local levels and parallel action within other professional associations not directly linked to the CCME. The report noted, also, that although only one of its 45 recommendations called for the reconsideration of existing legislation, the implementation of many others required conjoint administrative effort by no less than five departments of the executive branch of the federal government. The responsibilities of 54 professional licensure agencies within state or other jurisdictions were similarly involved.

Finally, the report stressed the finding that essentially all of its recommendations parelleled and, in some instances, coincided with the recommendations on foreign medical graduates made nine years earlier, in 1967, by the National Advisory Commission on Health Manpower (6). Consequently, the Council urged that measures be taken to facilitate and monitor progress in the implementation of its own recommendations.

Some observers undoubtedly concluded that the sweeping amendments to the Immigration and Nationality Act incorporated in the HPEA obviated the need for a continuing plan of followup. Such a conclusion has not been shared by all of the concerned private organizations nor by the responsible agencies of government. Title VI addressed only one segment of a much broader spectrum of issues identified in the Council's policy statement — many of which lay beyond the purview of Federal legislation. Moreover, the stringency of the language employed in Section 601 of the Act as well as in several subsequent technical amendments of Title VI (PL

95-83, PL 95-215), and the restrictions imposed by the Joint Conference report on the interpretation of Congressional intent, have given rise to a new set of problems.

For these reasons, the Coordinating Council again took formal action. In December 1978, it issued six specific recommendations to institutions engaged in graduate medical education in order to facilitate the full implementation of Title VI of PL 94-484. The Council also called on its parent organizations to report their current assessments of the FMG situation as well as their ongoing activities in this area and to propose further Council action that they might consider desirable. In addition, the Council invited the Educational Commission for Foreign Medical Graduates to assemble all data to which it might have access bearing upon changes in status of FMGs subsequent to the adoption of the Council's policy statement (7-8).

The ECFMG welcomed this invitation to prepare an analysis of the changing role of foreign medical graduates for presentation to the Coordinating Council. It traces its own origin in 1956 to a consensus reached at that time on the need for a unified nationwide program addressing some of the special problems in graduate medical education arising from the inclusion of physicians who had graduated from foreign medical schools where preparatory education might not be comparable to that provided in domestic schools. Initially, these problems were viewed as only temporary and self-limiting consequences of the post-World War II extension and expansion of this country's Good Neighbor Policy. The number of exchange visitor physicians expected to come for graduate clinical training, though unspecified, was not large. Moreover, it was believed that these exchange visitors would not impose a heavy burden on training institutions, especially in light of the marked growth in the number of unfilled residency positions then available in U.S. teaching hospitals. The serious shortages of trained physicians in the countries where these exchange visitors originated and to which they were expected to return, were viewed as providing reasonable assurances that they would not seek to settle permanently in the United States. Furthermore, the then prevailing laws and regulations mandated their departure immediately following the completion of their educational experience.

The tasks assigned initially to the ECFMG were somewhat circumscribed yet important: to evaluate the educational credentials of FMGs seeking graduate medical education within the U.S. and to determine their readiness to benefit from such training. To achieve the second objective, the National Board of Medical Examiners was commissioned to develop, from its large pool of validated test questions, a suitable examination, initially designated as the American Medical Qualifying Examination. Such a screening instrument established an appropriate basis for the standardization of the scores of candidates whose medical education had been acquired abroad with the technical competence demonstrated by graduates of U.S. and Canadian schools. There was general agreement, also, that achieving a passing score on the ECFMG examination gave reasonable assurances that the welfare of hospitalized patients receiving the supervised care provided by such physicians in training would not be jeopardized.

Those involved in the founding of the ECFMG as well as those involved in the issuance of entrance visas to the U.S. could not have anticipated the explosive growth in the number of FMGs applying for ECFMG certification that occurred within a brief span of years or that this heightened tide of migrant physicians would represent so many nationalities or diverse cultural heritages. Three landmark Federal enactments contributed to the transformation of foreign medical schools into significant sources of American physician manpower: the Fulbright-Hays (Mutual Educational and Cultural Exchange) Act of 1961 (PL 87-236) reorienting a critical component of this country's relationships with other countries; the 1965 amendments to the Immigration and Nationality Act (PL 89-236) terminating longstanding barriers to immigration from East Asian and Western Pacific countries and, in addition, establishing preferential immigration provisions based on occupational skills as well as on familial relationships; and PL 91-225, adopted in 1970, removing essentially all of the bars that had previously deterred an exchange visitor physician wishing to convert his temporary visa to an immigrant visa.

The flexibility written into the original charter of the ECFMG made it possible for it to respond directly to such major alterations in legislative mandate and to modify accordingly the scope and magnitude of its activities. The enactment of PL 94-484, as well as events occuring in the four plus years following the adoption of that Act, have also given rise to additional significant changes in ECFMG

programs and operations. Thus, more than 23 years of first-hand experience, including the assessment of the professional qualifications of a half-million examinees (initial and repeat) and the processing of an even larger number of applications submitted by FMGs seeking opportunities for graduate medical training within the U.S., uniquely qualifies the ECFMG to provide a broad range of insights into the changing status of FMGs within our health care system, especially during the early phases of their graduate clinical experience. Moreover, serving as it does as an extension of the many organizations, private and public, concerned with the special needs of FMGs and the problems linked with their study or practice of medicine in this country, places the ECFMG in a strategic position to correlate information reflecting its own activities with the data bases developed and maintained by other agencies and organizations.

Regrettably, before all of the data requested by the CCME could be compiled and prepared for presentation, the parent organizations of that body voted to replace it with a new entity, the Council for Medical Affairs, with extensively revised purposes and functions. Whether the new Council will, at some time in the future, wish to explore further the changing status of FMGs within our health care system is yet to be determined. The Board of Trustees of the ECFMG, however, following detailed review of the information incorporated within this report recommended to the author that its publication would serve a dual purpose: to provide a background document for a national invitational conference which the ECFMG will convene in early October 1981 as a means of encouraging appropriate broad scale discussion of the many remaining unresolved FMG issues; and to assist the ECFMG in its own continuing process of self appraisal.

It is also timely that these data be carefully considered in the framework of pending Federal legislation and of three recently released national reports. No less than five amendments to PL 94-484 received serious consideration by various committees of the 96th Congress. Only the extension of one provision for a single year, the substantial disruption waiver, has thus far been enacted into law. Similar measures have already been introduced into the 97th Congress which convened in January 1981. In addition, the Graduate Medical Education National Advisory Committee (GMENAC) urged in its final report to the Secretary of the U.S. Department of Health and Human Services, submitted in September 1980, that the barriers to the entrance of FMGs into U.S. medical practice established by the provisions of PL 94-484 be reinforced rather than relaxed (9). A highly critical report on foreign medical schools patronized by U.S. nationals studying abroad, prepared by the General Accounting Office at the request of the Subcommittee on Health and the Environment of the House of Representatives is now also being widely circulated (10). Another report only indirectly concerned with FMGs, that of the Select Commission on Immigration and Refugee Policy, was presented to President Reagan and the Congress on March 1, 1981. After three years of deliberations and multiple public hearings, the Commission's findings and final recommendations vigorously endorse major alterations in long established policies bearing upon the admission to the U.S. of immigrants and foreign visitors (11).

The extensive data presented in this "working paper" were assembled from multiple and essentially uncoordinated sources. Many of them, previously unpublished, have been interdigitated with other appropriate data readily available to those familiar with the periodic literature on medical education, both undergraduate and graduate, medical licensure and on physician distribution. As new information becomes available, supplementary tabulations will be compiled for distribution. In this endeavor the ECFMG seeks to advance two of its stated purposes, namely: to gather, maintain and disseminate data concerning foreign medical graduates; and to assist, through cooperation and recommendation, other agencies concerned with foreign medical graduates.

THE CHANGING IMPACT OF FMGs

A. ON THE TOTAL SUPPLY OF PHYSICIANS

As demonstrated above, multiple analytical reports as well as PL 94-484 were critical of the fact that during the decade immediately preceding the enactment of that legislation the U.S. had placed unjustifiable reliance on the output of medical schools abroad in order to meet its own expanding demands for physician services, especially for the supply of staff physicians required to provide round-the-clock care for hospitalized patients. To be sure, one group of observers had demonstrated that the reported number of foreign physicians migrating to this country was exaggerated by the duplicate counting of exchange visitor physicians who "adjusted" to permanent residents (12). However, no serious challenge can be offered to the charge that the U.S. had become, in a relatively short time, the world's largest importer of medical talent. Based on data available through the Physician Masterfile, maintained by the American Medical Association, the number of FMGs in the U.S. had increased between 1963 and 1973 from 36,569 (including 5,644 Canadian medical school graduates), or 13.2 percent of the total of 276,475 physicians, to 77,660 (including 6,325 Canadian medical graduates), or 21.2 percent of the 366,379 total of all physicians (13).

How has the FMG situation in the U.S. changed since the CCME compiled the data in 1974 on which it initially based its conclusions and recommendations? To provide a partial answer to this question Table 1 has been assembled from Physician Masterfile data comparing the relative contribution of each of the several sources of medical education of physicians (MDs) in the United States in three selected years: 1963, 1973 and 1979. Physician to population ratios and census estimates of the total U.S. population in each of those years are also presented.

It may be observed that the number of FMGs in the U.S. has continued to increase from 36,569 in 1963 and 77,660 in 1973 to 104,136 in 1979 (14). In the most recent year for which data are available, FMGs comprised 22.9 percent of the total number of physicians compared with 21.2 percent five years earlier and 13.2 percent in 1963. During the 17 years encompassed by this tabulation, the average annual net increase of FMGs amounted to 4,223; the comparable figure for graduates of U.S. medical schools was 6,991. If, however, the net annual increments in the total supply, domestic graduates and FMGs during the six year interval 1973-79 are compared with those occurring during the earlier ten-year period, 1963-73, some interesting differences may be noted.

During the earlier interval, 1963-73, the mean per annum increment in the total number of physicians amounted to 8,990 physicians; during the more recent period 1973-79, the comparable average annual increase amounted to 14,698 net additions to the total number of physicians. Examining the data more closely, it may be noted that the annual average net gains in the numbers of FMGs were approximately the same in the two intervals, 4,413 in the latter period and 4,109 in the earlier. This constancy occurred in the relatively small number of net additions of Canadian medical school graduates as well as in the more substantial number of net additions for graduates of medical schools in other non-U.S. countries.

The widely heralded recent increases in the total physician supply are reflections of the increased enrollments in the older established U.S. medical schools and the opening of newer additional schools; the average annual net increase in domestic medical school graduates rose from 5,015 in the period 1963-73 to 10,285 in the more recent interval, 1973-79. It may be inferred, therefore, that the U.S. is now producing a larger fraction of all physicians engaged in medical practice in the U.S. than was the case a relatively few years ago. Nonetheless, as of December 31, 1979 more than one in five physicians in the U.S. (22.9 percent) gained his basic medical education abroad. Moreover, while the proportional contribution of FMGs to the annual average increments in the U.S. physician supply has been declining from its peak of approximately 45 percent of the total (4,109/8,990) during the period 1963-73, medical school graduates from abroad are continuing to contribute, as of 1973-

TABLE 1
THE SUPPLY OF PHYSICIANS (M.D.s) IN THE U.S.
1963-1979

	Aggregate Supply as of December 31		
	1963	*1973*	*1979*
Total Physicians	276,475*	366,379	454,564
U.S. Graduates	238,571	288,719	350,428
Foreign Graduates	36,569	77,660	104,136
Canadian	5,644	6,325	7,531
Other	30,925	71,335	96,605
Percent FMGs	13.2	21.2	22.9
Physicians per 100,000 Population			
Total	146	174	205
USMGs	126	137	158
FMGs	19	37	45
Total U.S. Population (in thousands)	189,242	210,908	221,582

	Average Annual Increases					
	1963-1979		*1963-1973*		*1973-1979*	
	Number	*Percent*	*Number*	*Percent*	*Number*	*Percent*
Total Physicians	11,131	4.0	8,990	3.3	14,698	4.0
U.S. Graduates	6,991	2.9	5,015	2.1	10,285	3.6
Foreign Graduates	4,223	11.5	4,109	11.2	4,413	5.7
Canadian	118	2.1	68	1.2	201	3.2
Other	4,105	13.3	4,041	13.1	4,212	5.9
Total U.S. Population (in thousands)	2,021	1.1	2,167	1.1	1,779	0.8

*Includes 1,335 physicians, addresses unknown, who are not distributed according to sources of medical education.

Sources: Distribution of Physicians in the U.S., 1973, American Medical Association, Chicago, 1974; Physician Distribution and Medical Licensure in the U.S., 1979, American Medical Association, Chicago, 1981.

T.D.D./Revised 1-12-81.

1979, a substantial fraction — 30 percent (4,413/14,698) — of the average annual net rise in the total number of physicians.

The relative rates of growth of the several sources of the physician supply compared with the slower rate of population increase also merit comment. For the overall 16 year interval, the rate of increase of the total number of physicians has averaged 4.0 percent per year or almost four times the rate of increase of the total population. From the discussion above it should be apparent that the rate of increase in the number of physicians accelerated between 1963-73 and 1973-79; the actual rates of increase during those two intervals were 3.3 percent and 4.0 percent per year, respectively. This was largely the result of the greater rate of increase in the domestic supply which rose from 2.1 percent per year in the earlier interval to 3.6 percent per year during the six more recent years. Although the whole number of FMGs added each year remained, on the average, essentially the same in the two time periods, the rate of increase actually declined from 11.2 percent per year to 5.7 percent; nonetheless, the rate of increase of FMGs, especially those originating in countries other than Canada, continues to outpace the corresponding rate of increase in the domestic supply, even in the 1973-79 time period (5.9 percent vs. 3.6 percent).

Table 1 also lists the ratios of physicians per 100,000 total population for each of the three selected years. For the total supply this ratio has risen from 146 in 1963 to 205 in 1979. The relative contributions of domestic and external sources to these highly favorable ratios are also displayed. Note that the ratio of USMGs per 100,000 population was 158 in 1979 or one graduate of a domestic medical school for every 633 persons in the total population. Granting that such a comparison is a hypothetical one, it is of interest that this level of availability of U.S. trained physicians is somewhat

higher than the total physician to population ratio of 146 per 100,000 in 1963 when there was one physician (regardless of the source of his basic medical education) for every 685 persons in the general population.

B. ON PHYSICIAN LICENSURE

Table 2 lists the number of physicians granted their initial licenses to practice medicine in the U.S. in each of the 20 years, 1960 through 1979. In large measure the data included in Table 2 complement the slightly different type of data presented for selected years in Table 1. In the earlier table the increments between years are *net* additions, that is the number of individuals who have received a medical degree and whose medical credentials have been recorded in the AMA Physician Masterfile minus the number of physicians who have died. Also subtracted from the total is the number of physicians known to have left the country. Table 2 has been compiled also from data collected and published annually by the AMA. It is unique in that it presents the total number of newly licensed physicians admitted to practice for the first time in a

TABLE 2
INITIAL LICENSURE OF PHYSICIANS IN THE U.S.
NEW ADDITIONS TO THE MEDICAL PROFESSION
1960-1979

Year	*Total New Licentiates*	*U.S. and Canadian Graduates*	*FMGs (Other than Canadian Graduates)*	
			Number	*Percent*
1960	8,030	6,611	1,419	17.7
1961	8,023	6,443	1,580	19.7
1962	8,005	6,648	1,357	17.0
1963	8,283	6,832	1,451	17.5
1964	7,911	6,605	1,306	16.5
1965	9,147	7,619	1,528	16.7
1966	8,851	7,217	1,634	18.5
1967	9,427	7,346	2,081	22.1
1968	9,766	7,581	2,185	22.4
1969	9,978	7,671	2,307	23.1
1970	11,032	8,016	3,016	27.3
1971	12,257	7,943	4,314	35.2
1972	14,476	7,815	6,661	46.0
1973	16,689	9,270	7,419	44.5
1974	16,706	10,093	6,613	39.5
1975	16,859	10,894	5,965	35.4
1976	17,724	11,288	6,436	36.3
1977	18,175	12,324	5,851	32.2
1978	19,393	14,815	4,578	23.6
1979	19,896	16,330	3,566	17.9
Total	250,628	179,361	71,267	28.4
Averages:				
1960-79	12,531	8,968	3,563	28.4
1960-64	8,050	6,628	1,423	17.7
1965-69	9,434	7,487	1,947	20.6
1970-74	14,232	8,627	5,605	39.4
1975-79	18,409	13,130	5,279	28.7

Sources: Medical Licensure 1973, Statistical Review, Journal of the American Medical Association, 229:445-456, July 22, 1974; Physician Distribution and Medical Licensure in the U.S., 1974, 1975, 1976, 1977 and 1978, American Medical Association, Chicago, 1975, 1976, 1977, 1978 and 1979; Physician Distribution and Medical Licensure in the U.S., 1979, American Medical Association, Chicago, 1981.

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given year in any of the 54 separate licensing jurisdictions within the U.S. and its territories. Concerted efforts have been made to eliminate duplications that might result from the licensure and practice of a physician in more than one state or from the revalidation of a license initially granted in a prior year; recently assembled evidence suggests, however, that some double counting of initial licenses granted, especially to FMGs, may have occurred because of the limited resources available in a few states to eliminate such duplicate enumeration (14).

From this table it may be noted that for U.S. and Canadian medical school graduates combined, the number of new licentiates remained remarkably constant from 1960 through 1964 at about 6,600 per year, rose modestly and remained reasonably stable at the 7,500 level from 1965 through 1969, and then began to rise quite steadily in the early 1970s to reach the level of 16,330 in 1979. For FMGs (other than Canadian medical school graduates) a somewhat different configuration may be perceived. For the seven years 1960 through 1965, the number of initially licensed FMGs also remained quite stable at about 1,500 per year, averaging under 18 percent of the total of new licensees annually. In 1967, the second year following the lifting of restrictions on the immigration of nationals of Far Eastern countries and the granting of occupational preferences to physicians, the number of newly licensed FMGs rose to exceed, for the first time, 2,000 and then doubled to reach 4,314 in 1971. The increased output of domestic medical schools (see Table 6) could already be noted by 1971 but was not yet sufficient to counterbalance the rising tide of FMGs acquiring the credentials needed to enter the independent practice of medicine in this country. The proportion of all new licentiates that year who were graduates of medical schools outside the U.S. and Canada mounted to slightly over 35 percent, more than double their fraction of the total about five years earlier. By 1973, three years after the Immigration and Nationality Act was amended to remove essentially all restrictions on exchange visitor physicians who elected to become permanent residents, the number of new FMG licentiates spurted to its peak of 7,419, about 45 percent of the newly licensed physicians entering practice that year. Since then, the number of new FMG licentiates has declined steadily to 4,578 in 1978 and 3,566 in 1979, the smallest number since 1970. As a result of the steadily increasing number of U.S. medical school graduates acquiring licenses to practice, the fraction of the total of new licentiates who are FMGs is declining and in 1979 reached 17.9 percent, its lowest point since 1965.

These downward trends cannot be attributed solely to the new barriers to the entry of physicians to this country invoked by Title VI of PL 94-484, enacted in October 1976. None of these curbs on migration took effect prior to January 1977 and some did not become operative until January 1978. Bearing in mind that it is next to impossible for a physician to obtain a license to practice medicine from any state or territorial licensing authority in less than two years following his entry into the U.S., the full impact of PL 94-484 on the number of new FMG licentiates only began to be felt, at the earliest, in 1979.

A comparison of the data presented in Tables 1 and 2 permits another, perhaps incidental observation. Note in the former that all physicians known to the Physician Masterfile as of December 31, 1979 totaled 454,564; of these, 96,605 or 21.3 percent were foreign medical graduates, exclusive of Canadians. Table 2 records that in the period covered, the most recent 20 year interval 1960-79, a total of 250,628 physicians were granted their initial licenses to practice. It may be inferred from these data that over half of all of the physicians in the U.S. (55.1 percent) began their independent practice of medicine during this relatively short time span. Of this, presumably, the most active segment of the total physician supply, 71,267, or over 28 percent, are graduates of medical schools located outside the U.S. and Canada. If one could also assume that all of these 71,267 newly licensed FMGs are still alive and have remained in the U.S., they constitute almost three of every four of the total of 96,605 FMGs (excluding CMGs) known to the Physician Masterfile at the end of calendar year 1979; a part of the difference between these two figures may include FMGs who were at that time hospital residents, hospital staff members or others known to the Masterfile but not eligible for or not yet granted a license to practice independently, thus emphasizing further that FMGs as a group are predominantly in the earlier years of practice.

The 1976 CCME report observed that in 14 states of the then 55 separate state and territorial licensing jurisdictions, 50 percent or more of the initial licensees in 1974 were FMGs (excluding CMGs). A year earlier, in 1973, when the total number of initial licenses granted to FMGs had reached its

peak of 7,419, 19 states experienced these surprisingly high ratios of new FMG licentiates to the total of all initial licensees. As shown in Table 3, the number of states in which 50 percent or more of initial licensees were FMGs has declined markedly to three in 1979, the most recent year for which such data are at present available. The overall fraction of FMG initial licensees has declined from 45 percent in 1973 to 18 percent in 1979.

Conspicuous by their absence in the 1979 tabulation of states in which the majority of newly licensed physicians are FMGs, (at the bottom of Table 3) are four of our most populous states — Illinois, Michigan, New York and Pennsylvania — where, for some years, the actual number and the fraction of the total of new FMG licentiates have been high. In these and other states considerably fewer FMGs obtained initial licensure in 1979 in comparison with 1973; concurrently, more U.S. graduates received their first licenses and consequently the

TABLE 3
INITIAL LICENSURE OF PHYSICIANS IN THE U.S.
1973 and 1979
(States, or Territories, with 50% or More Initial Licenses Granted to Foreign Medical Graduates)

State	*USMGs*	*FMGs*	*Total*	*%FMGs*
	1973			
Virgin Islands	0	2	2	100.0
Maine	26	216	242	89.8
North Dakota	12	65	77	84.4
Delaware	11	33	44	75.0
Puerto Rico	47	117	164	71.3
Michigan	342	844	1,186	71.2
New Hampshire	8	18	26	69.2
New Jersey	86	192	278	69.1
Illinois	345	766	1,111	68.9
Pennsylvania	501	938	1,439	65.2
District of Columbia	91	153	244	62.7
Virginia	145	244	389	62.7
Florida	230	348	578	60.2
Wyoming	2	3	5	60.0
New York	973	1,426	2,399	59.4
Missouri	141	204	345	59.1
Rhode Island	19	23	42	54.7
Vermont	95	104	199	52.3
West Virginia	45	48	93	51.6
Total — 19 States	3,119	5,744	8,863	64.8
Total — All States	9,270	7,419	16,689	44.5
	1979			
Virgin Islands	0	1	1	100.0
Maine	96	187	283	66.1
New Jersey	141	201	342	58.8
Total — 3 States	237	389	626	62.1
Total — All States	16,330	3,566	19,896	17.9

Sources: Medical Licensure, 1973, Statistical Review, Journal of the American Medical Association, 229:445-456, July 22, 1974; Physician Distribution and Medical Licensure in the U.S., 1979, American Medical Association, Chicago, 1981.

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proportion of the total of new licensees who are FMGs declined in Michigan to 32 percent, in Illinois to 22 percent, in New York to 21 percent and in Pennsylvania to 19 percent. These tabulations as well as other available evidence suggest that in the period 1973-1979, FMGs were becoming more widely dispersed in a larger number of states. This development, coupled with an appreciable reduction in the total number of newly licensed FMGs, has resulted in a notable diminution in the number of states where USMGs form only a minority of all newly licensed physicians.

C. ON HOSPITAL STAFFING AND GRADUATE MEDICAL EDUCATION

No discussion of the role of FMGs within the U.S health care system and recent changes in that role could be complete without a detailed analysis of FMG participation in hospital residency and other graduate hospital training programs. National concern first arose as a result of the accelerating flow of larger numbers of these physicians into our hospital staffing patterns. Initial concern was quickly compounded by the recognition that all but a few had origins in the far distant corners of the world where languages, cultures and even educational practices differ markedly from our own. Were these migrant physicians-in-training adequately or even appropriately prepared for the demanding roles into which they were being catapulted as interns and residents in teaching hospitals, their sole portal into graduate medical education or medical practice in the U.S.? The figures presented in Table 4 permit a comparison of graduates of foreign medical schools with U.S. and Canadian medical school graduates in terms of the predominant type of physician activity in which they were engaged in 1970 and nine years later, in 1979 (14-15).

Data compiled in 1970 by the AMA Center for Health Services Research and Development, demonstrate that 27,211 or 47.6 percent of the 57,217 FMGs (exclusive of CMGs) were in hospital-based practice, 29.1 percent as interns or residents and 18.5 percent in other full-time hospital physician staff positions. Corresponding figures for graduates of U.S. and Canadian medical schools were 58,885 in hospital-based practice or 21.3 percent of the total of 276,811; 34,580 or 12.5 percent of all U.S. and Canadian medical school graduates were serving as interns or residents and an additional 24,305 or 8.8 percent of the total were in other full-time hospital-based physician posts. In that same year, 1970, 17.1 percent of all physicians in the U.S. had received their medical degrees outside of this country or Canada. Among hospital based physicians, the corresponding figure was 31.6 percent; 32.5 percent of all interns and residents were FMGs (exclusive of CMGs) and 30.3 percent of all other full-time physician staff members in hospitals shared such a background (15).

By 1979, these figures had changed significantly. The fraction of all FMGs in the U.S. who were engaged in hospital-based practice had fallen from almost one half of the total (47.6 percent) to less than a third of the total (30.1 percent). Moreover, while the fraction of all U.S. and Canadian medical school graduates who were in residency training programs had increased slightly between 1970 and 1979 from 12.5 percent to 14.3 percent, the proportion of foreign medical school graduates who were in similar graduate training programs had declined from 29.1 percent to 13.5 percent; FMGs in other full-time hospital staff positions had increased from 10,563 to 15,957 and in 1979 represented 16.5 percent of all FMGs in the U.S. Corresponding data for graduates of U.S. and Canadian medical schools, in 1979, indicated that 21.8 percent of the total of 357,959, or 78,155 physicians were engaged in hospital based practice, 14.3 percent at the residency level and 7.5 percent in other full-time hospital staff positions. Thus, the fraction of FMGs in this country who are in training status (residents) has diminished in recent years and now approximates the proportion of U.S. and Canadian graduates who are at a similar stage of their career (14.3 percent versus 13.5 percent); on the other hand, FMGs are twice as likely to accept full-time hospital staff positions than are their U.S. and Canadian trained counterparts (16.5 percent versus 7.5 percent of the total supply).

Based on the data in this same Table 4, it appears that the proportion of all physicians who were graduates of schools located outside of the U.S. and Canada had risen slightly from 17.1 percent of the total in 1970 to 21.3 percent in 1979. However, the fraction of physicians in hospital based practice who were FMGs declined during this same period from 31.6 to 27.1 percent. In 1970, 16,648 or 32.5 percent of the 51,228 residents in hospital training programs were FMGs; by 1979, the number of FMG residents had fallen to 13,086 and represented only 20.4 percent of all hospital residents. Concurrently, in 1970, 10,563 or 30.3 percent of the 34,868 other full-time hospital staff members were FMGs; by 1979, the number of FMG full-time hos-

TABLE 4
ACTIVITY DISTRIBUTION OF PHYSICIANS IN THE U.S. BY SOURCE OF MEDICAL EDUCATION
1970 and 1979

	Number			Percent		
	USMGs & CMGs	*Other FMGs*	*All*	*USMGs & CMGs*	*Other FMGs*	*All*
			1970			
All Physicians	276,811	57,217	334,028	100.0	100.0	100.0
Office Based Practice	171,459	20,980	192,439	61.9	36.7	57.6
Hospital Based Practice	58,885	27,211	86,096	21.3	47.6	25.8
Residents	34,580	16,648	51,228	12.5	29.1	15.3
F. T. Physician Staff	24,305	10,563	34,868	8.8	18.5	10.4
Other Prof. Activity	26,359	5,951	32,310	9.5	10.4	9.7
Inactive	17,800	1,821	19,621	6.4	3.2	5.9
Not Classified & Address Unknown	2,308	1,254	3,562	0.8	2.2	1.1
			1979			
All Physicians	357,959	96,605	454,564	100.0	100.0	100.0
Office Based Practice	205,886	43,699	249,585	57.5	45.2	54.9
Hospital Based Practice	78,155	29,043	107,198	21.8	30.1	23.6
Residents	51,208	13,086	64,294	14.3	13.5	14.1
F. T. Physician Staff	26,947	15,957	42,904	7.5	16.5	9.4
Other Prof. Activity	29,294	7,652	36,946	8.2	7.9	8.1
Inactive	25,663	2,675	28,338	7.2	2.8	6.2
Not Classified & Address Unknown	18,961	13,536	32,497	5.3	14.0	7.1

Sources: Distribution of Physicians in the United States, 1970, American Medical Association, Chicago, 1971; Foreign Medical Graduates in the United States, 1970, American Medical Association, Chicago, 1971; Physician Distribution and Medical Licensure in the United States, 1979, American Medical Association, Chicago, 1981.
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pital staff members had increased to 15,957 and to 37.2 percent of the 42,904 physicians engaged in this type of activity.

One startling finding to be noted in Table 4 is that in the nine-year interval between 1970 and 1979, the number of physicians whose addresses were unknown or for whom insufficient information was available to permit an appropriate classification of type of professional activity, rose from 3,562 to 32,497 or from 1.1 percent of the total to 7.1 percent. In 1979, among graduates of U.S. and Canadian medical schools, 18,961 of the total of 357,959 or 5.3 percent were either unclassified or with unknown addresses; for FMGs, excluding CMGs, 13,536 or 14.0 percent of the total of 96,605 fell into these categories. It is difficult to assess the extent to which these increases in the number of unclassified individuals may affect the validity of the reported changes in distribution. This uncertainty applies especially to the unusually high number of unclassifiable FMGs who, at year-end 1979, amounted to essentially one in seven of all FMGs recorded in the AMA Physician Masterfile.

Table 5 provides more detailed insights into the changing role of foreign medical graduates participating in accredited graduate medical education programs. The number of residents (including interns) and of other trainees reported to be on duty as of September 1 of each of the selected years during the 29 year interval, 1950-51 to 1979-80, are listed. (In this table, as in the preceding one, Table 4, Canadian medical school graduates are grouped with graduates of U.S. schools; thus, the term FMG used in connection with these tables applies to graduates of other foreign medical schools.) Long-term trends in the number of positions offered, filled, filled by non-FMGs, filled by FMGs and positions vacant are displayed. Also shown are the parallel trends for other training programs in accredited institutions and the number and percent of such trainees who are FMGs.

In examining Table 5, note that except for a tem-

porary decline in the mid 1970s the number of training positions offered has been mounting steadily. The number of positions filled by U.S. and Canadian graduates has also been rising during the period under consideration. However, this number has consistently lagged behind the number of positions available. In the minds of some observers, the continuing gap between the "demand for residents" and the domestic "supply" has served as a continuing vacuum drawing to this country FMGs capable of meeting the established qualifications for appointment to such positions. In the mid 1960s and early 1970s, over 40 percent of all residency positions offered in accredited programs would have remained unfilled had there not been available qualified FMGs to occupy some of them. Even in 1979-80, the most recent year for which data are available, almost one in four of all residency posts might be vacant were no FMGs permitted to accept appointment to them. With some 12,000 FMGs on duty as residents that year the number of vacant positions reported by training program directors was reduced to 4,421, 6.4 percent of the total number of positions offered.

As one scans the trend of residency positions filled by FMGs, it is pertinent to keep in mind the three Congressional enactments that contributed substantially to the increasing numbers mentioned above, namely, the Mutual Educational and Cultural Exchange Act of 1961 and the 1965 and 1970 amendments to the Immigration and Nationality Act. The peak in the number of FMGs occupying such posts was reached during academic year 1972-73 when their share of all residents also reached its high point of 32.7 percent. It is of interest that during the four academic years 1971-72 to 1974-75 the number of all FMGs in training positions, other trainees as well as residents, achieved a high plateau between 21,500 and 22,300; without question, the rate of year to year increases characterizing the preceding twenty or so years had tapered off.

It is regrettable that the type of data presented in Table 5 was not assembled and published for the year 1975-76 and some of the data for more recent years are less comprehensive than those available for the earlier period. Nonetheless, this tabulation together with information derived from multiple other sources strongly support the conclusion that

TABLE 5

INTERNS, RESIDENTS AND OTHER TRAINEES IN ACCREDITED HOSPITAL GRADUATE MEDICAL EDUCATION PROGRAMS, BY SOURCE OF UNDERGRADUATE MEDICAL EDUCATION, ACADEMIC YEARS, 1950-51 TO 1979-80

	Internship and Residency Program							*Other Training Programs*		
Academic Year	*Positions Offered*	*Positions Filled*	*Filled by Non-FMGs*	*Filled by FMGs Number*	*Percent*	*Positions Vacant Number*	*Percent*	*Total Trainees*	*FMG Trainees*	*Percent FMGs*
1950-51	28,039	21,525	19,453	2,072	9.9	7,209	25.7	*	*	—
1955-56	38,132	31,029	24,995	6,033	19.4	7,104	18.6	*	*	—
1960-61	45,333	37,562	27,627	9,935	26.4	7,711	17.1	*	*	—
1965-66	51,933	41,568	30,074	11,494	24.9	10,365	20.0	5,725	2,355	41.1
1970-71	61,938	51,015	34,708	16,307	32.0	10,923	17.6	7,822	3,321	42.6
1971-72	65,615	54,578	37,090	17,489	32.0	11,037	16.8	9,173	4,106	44.8
1972-73	65,308	56,244	37,849	18,395	32.7	9,064	13.9	9,038	3,595	39.8
1973-74	66,302	60,113	41,765	18,348	30.5	6,189	9.3	9,324	3,499	37.5
1974-75	68,122	62,512	44,381	18,131	29.0	5,610	8.2	10,854	4,186	38.6
1975-76	*	*	*	*	—	*	—	*	*	—
1976-77	65,046	60,561	45,065	15,496	25.6	4,485	6.9	9,986	3,748	37.5
1977-78	*	56,019	42,310	13,709	24.5	*	—	*	*	—
1978-79	*	63,163	50,342	12,821	20.3	*	—	*	*	—
1979-80	69,036	64,615	52,550	12,065	18.7	4,421	6.4	*	*	—
1980-81	70,672									

*Data not available.

Sources: Directories of Approved Internships and Residencies, 1951-52 to 1973-74; Directory of Approved Residencies, 1974-77; Directories of Accredited Residencies, 1975-76 and 1977-78; '80/'81 Directory of Residency Training Programs Accredited by the Liaison Committee on Graduate Medical Education, American Medical Association, Chicago.

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academic year 1974-75 signaled the end of an era with respect to the massive involvement of FMGs in graduate medical education in this country. Certainly, in no subsequent year for which data are available has the number of FMGs enrolled in accredited residency programs exceeded or even equaled the number reported for that year. From 1976-77 to 1979-80 the number of FMGs has steadily dropped from 15,500 to about 12,000 enrolled as residents and from about 26 to 19 percent of the total.

As noted above and despite the reduction in the number of FMG residents on duty, the 1970s have also been marked by the reduction in the number of residency positions vacant. In 1970-71 there were about 62,000 residency positions offered. Even though more than 16,000 of these were filled by FMGs there remained approximately 11,000, or more than one in six, unfilled. Nine years later, in 1979-80, the number of residency positions had increased to over 69,000; 12,000 were filled by FMGs and 4,400 or 6.4 percent of the total positions were vacant. This development is readily traceable to increases in the number of graduates of U.S. medical schools. As shown in Table 6, this heightened "productivity" of medical education in this country began to appear during the mid-1960s and has accelerated during the 1970s. The continuing increases in the number of U.S. medical schools, first year enrollment and total enrollment in these institutions as well as in the number of M.D. degrees awarded, foreshadow a continuation of this trend for some years to come.

Recently, Goodman and his associates on the staff of the AMA Center for Health Services Research and Development have published a series of reports substantiating the recent decline in the number of FMGs participating in residency training programs in U.S. hospitals (16). Their analyses also suggest that the reduction in numbers was greater than had been discernible from other then available data. Based on the year-end Physician Masterfile data for the five year interval 1975-1979, these studies may be compared with those traditionally reported by the staff of the AMA Department of Graduate Medical Education only if the differences in the compilation procedures employed with the separate and distinct sets of data are clearly recognized.

The Graduate Medical Education Directory tabulations, referred to above, are derived from the program reports submitted annually by hospital directors of GME programs as an integral component of educational accreditation procedures. The quantitative information provided includes the number of residents, or other designated trainees, known to be on duty as of September 1 of a specified

TABLE 6
NUMBER OF STUDENTS AND GRADUATES — U.S. MEDICAL SCHOOLS
1930-31 to 1979-80

Year	*Number of Schools*	*First Year Enrollment*	*Total Enrollment*	*Number of Graduates*
1930-31	76	6,456	21,982	4,735
1940-41	77	5,837	21,379	5,275
1950-51	79	7,177	26,186	6,135
1960-61	86	8,298	30,288	6,994
1970-71	103	11,348	40,487	8,974
1971-72	108	12,361	43,650	9,551
1972-73	112	13,726	47,546	10,391
1973-74	114	14,185	50,886	11,613
1974-75	114	14,963	54,074	12,714
1975-76	114	15,351	56,244	13,561
1976-77	116	15,667	58,266	13,607
1977-78	122	16,134	60,456	14,396
1978-79	125	16,620	62,754	14,966
1979-80	126	17,014	64,195	15,135

Sources: Medical Education in the United States, 1974-75, 75th Annual Report, Journal of the American Medical Association, 234:1325-1432, December 25, 1975; Medical Education in the United States, 1979-80, 80th Annual Report, Journal of the American Medical Association, 244:2795-2872, December 26, 1980.

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year. The accuracy and validity of the data supplied are vouched for, as of that date, by responsible institutional representatives. Data derived from the Physician Masterfile, on the other hand, are dependent upon these and multiple other reporting mechanisms. They are reported as representing end of year status rather than for the earlier date utilized by the Directory of Residency Training Programs. Since all data applicable to an individual physician is entered into that physician's permanent historical record in the Masterfile, a diligent effort is made to verify every entry and eliminate inaccurate or inconsistent information. A period of months may elapse before a significant career change or alteration of professional activity takes place and a confirmed entry made into the Masterfile. This deliberate emphasis on verified information may explain, in part, why, as considered elsewhere above, the number of physicians included in the Masterfile for whom information is lacking or so out of date that proper locational, activity or specialty classification cannot be assigned, has increased rapidly in recent years. (See Table 4).

The Physician Masterfile data indicate that as of December 31, 1975 there were 57,802 physicians occupying residency posts in teaching hospitals; of these, 16,460 or 28.5 percent were FMGs. Four years later, at year-end 1979, the number of residents listed in the Masterfile had risen to 65,910; of these, 11,649 or 17.7 percent were graduates of medical schools located elsewhere than in the U.S. and Canada. In light of the differences in the sources and procedures employed in the collection of these two sets of data, it is not surprising that discrepancies can be noted in the totals reported. For example, in 1976 the Center count of FMGs was seven percent higher than the Directory enumeration and in 1979 it was about four percent lower.

Taken collectively, however, available evidence indicates that there has been a definite diminution and, perhaps, an accelerating decline in both the actual number of FMGs in accredited training programs and in their fractional representation among all hospital residents as well as other graduate trainees. The actual decline in the number of FMGs involved in these programs may have begun as early as the program year 1973-74. With the wisdom of hindsight it is possible to detect that the rate of increase in the number of FMGs participating in accredited programs of graduate medical education had started to slacken as early as program year 1972-73. In either event, it should be apparent that an alteration in trend of FMG participation in these kinds of experience in this country commenced in advance of both the formal adoption of the CCME Policy Statement and the enactment of PL 94-484; certainly, well in advance of the effective dates of the various restrictions on physician migration to this country invoked by Title VI of that Act and by PL 95-83.

These inferences, based on data that only recently have become available, do not imply that the reduction in number of FMG residents observed since 1976-77 would have occurred regardless of the pronouncements of the Coordinating Council on Medical Education or of Congressional enactments. Quite the contrary interpretation is in order: If the reduction in the cadre of FMGs in U.S. hospitals continues to follow its most recent trend, and there is every reason to anticipate that it will, the observed decline does not yet reflect the full force of the restraints imposed by Title VI of PL 94-484 and subsequent clarifying amendments. The full impact of the higher and more inflexible barriers to the migration of physicians from abroad that are now in place may only become apparent with the further passage of time and the collection of additional and more current data.

When PL 94-484 was under consideration the Congress was alerted to the possibility that a marked reduction in the number of FMG residents, especially if such a limitation were instituted precipitously, could result in the curtailment of patient care services provided by certain types of hospitals. Ample documentation was available to establish that FMG residents were heavily concentrated in larger state, county, city and church owned hospitals and particularly those located within the metropolitan centers of ten Northeastern and North Central states. A similar type of concentration occurred in the training programs for some nine different medical specialties. There was evidence, also, indicating that these locations, institutions and programs were not attracting the graduates of U.S. medical schools seeking opportunities for graduate training; in fact, many of the programs patronized by FMGs had few and in some instances no U.S. medical school graduates participating in their training activities (16). Equally well recognized was the fact that many of these institutions served as the principal or sole source of medical care for large segments of the American population identified as the urban poor, members of minority ethnic groups

or otherwise disadvantaged (17-20).

To buffer such a selectively adverse impact, the new law and related regulations were framed so as to permit hospitals threatened with the substantial disruption of their services by the new restrictions on the employment of FMG residents, to apply for the waiver of two of the more stringent requirements. Four different categories of institutional need were identified. Waivers would be granted on a diminishing basis over a three year transitional period, 1978 to 1980. During that interval accredited hospital programs even though they were not affiliated with a medical school would be permitted to recruit an FMG resident who met all other requirements for an Exchange Visitor visa except for the satisfactory completion of the new Visa Qualifying Examination (VQE). An FMG resident so recruited could fill a position for which a waiver had been obtained and which could not be filled from the pool of U.S. medical school graduates or by the appointment of a fully-qualified FMG.

Even at the present time, after the Congress has extended the transitional period for an additional year, or until December 1981, information on the extent and severity of the resultant disruption of patient care services in hospitals is largely anecdotal. The data that are available are limited to the number of institutions that have applied for waivers, the number and specialty of the residency positions for which waivers have been requested and the number of waivers granted. In 1978, the initial year in which these provisions of PL 94-484 were in effect, 25 institutions applied for waivers for 35 positions; the Substantial Disruption Waiver Review Board administered by the D/HEW, granted waivers for 19 positions. In the second year, 1979, the number of applying institutions increased to 32 and the number of waivers requested rose more abruptly to 140; 108 waivers were awarded. In the third year, 1980, 63 institutional applications were submitted for 253 positions and the Review Board acted favorably on 239.

Of interest is the finding that institutions applying for waivers have been located preponderately in or around New York City even though applying hospitals were located in 20 different states in 1978, 13 in 1979 and 16 in 1980. 188 of the 253 hospital positions for which waivers were requested in 1980 are located in or around New York City. Since the Waiver Review Board began to function a total of 418 waiver requests have been reviewed; of these 170 have been for residency positions in Pediatrics, 66 in Psychiatry, 53 in Internal Medicine, 44 in General Surgery, 41 in Anesthesiology, 20 in Pathology, 10 in Neurology, 7 each in Radiology and Physical Medicine, 4 in General or Family Practice, 2 each in Neurosurgery and Obstetrics and Gynecology, and one each in Ophthalmology, Cardiothoracic Surgery and Urology.

Some observers have interpreted the above figures as indicating that the disruption of patient care services that has occurred as a consequence of the curtailment of FMG residents has been far less extensive than had been anticipated either by the Congress or by others. It is also possible that hospitals previously dependent largely on FMG residents were able to adapt quickly to the need for qualified personnel either by recruiting larger numbers of U.S. graduates, by employing nurse practitioners or formally trained physician assistants, by enlarging their staffs of full-time physicians who had already completed formal training or by devising other means of meeting service needs of their clientele. Substantive evidence to this effect, however, is not now available.

Nor is it possible to predict with confidence the extent and nature of the disruption of patient care services that may occur in future years in some training institutions if, as can reasonably be predicted, further declines in the number of FMG residents and other graduate trainees will occur during the next few years. The disruption of essential hospital services could be aggravated further should the anticipated increase in the output of domestic medical schools fail to provide either the number or types of replacements believed to be needed. To be sure, vacancies have always existed in certain categories of residency positions; some institutions, especially in recent years, have reduced appreciably the number of training positions offered because of a dearth of suitably qualified candidates, the curtailment of training funds or for other reasons. Whether the recently reported recommendations of the Graduate Medical Education National Advisory Committee offer acceptable approaches to the matching of our domestically trained supply of physicians to precisely measured needs for services, including those originating within hospitals, is yet to be determined (9). The fact remains, however, that residents in training, whether FMG or USMG, provide an appreciable volume of essential patient care services that cannot always be provided by attending physician staffs or that demand the performance of professional and

technical tasks that cannot be delegated to non-physician personnel (21).

D. ON VISAS ISSUED TO PHYSICIANS

Essential to the main thrust of this report are the data originating within the Immigration and Naturalization Service of the Department of Justice which indicate the number of physicians who enter the U.S. each year either as immigrants seeking permanent residence in this country or as temporary visitors who are expected to return to their country of origin after gaining specialized training or after completing some professional task requiring their unique skills. Table 7 has been compiled from the annual reports of the INS, modified slightly by the addition of previously unpublished data on the "adjustment" of visas. These latter data also originate within the INS yet they have been tabulated each year by the National Science Foundation as an integral element of the Foundation's ongoing studies of immigrant scientists and engineers in the U.S.

Before reviewing the specific figures presented in this tabulation of data covering the interval July 1, 1968 through September 30, 1978, it is again necessary to caution that a serious double counting error occurs when the number of physicians included in each of the two categories — recipients of permanent visas and those who acquire a temporary visa — are simply added together to arrive at a single total of all physicians admitted to this country (12). Such "inflated" counts have appeared in many reports on FMGs over the years and result from the bookkeeping procedure adopted by the INS wherein each "entry" to the U.S. is counted separately. As a consequence of the 1970 amendments to the Immigration and Nationality Act the procedures permitting a temporary visitor physician to "adjust" or

TABLE 7
PHYSICIANS ADMITTED TO THE UNITED STATES, BY VISA STATUS AT TIME OF ADMISSION AND BY FISCAL YEAR OF ADMISSION
1970-1979*

Visa Status	*1970*	*1971*	*1972*	*1973*	*1974*	*1975*	*1976*	*T.Q. 1976*	*1977*	*1978*	*1979*	*Total*	*Av. Per Year*
Immigrant Physicians													
Total Admitted	3,158	5,756	7,144	7,119	4,537	5,361	6,184	1,305	7,073	4,435	3,040	55,112	5,376
Beneficiaries of Occupational Preference	840	1,484	1,671	1,729	1,685	1,902	1,909	357	2,093	1,071	623	15,364	1,499
Third Preference													
Admissions	544	564	540	676	663	953	822	161	755	146	321	6,145	600
Adjustments	166	557	840	948	761	653	907	152	1,172	743	194	7,091	692
Sixth Preference													
Admissions	84	90	44	17	79	67	44	26	35	23	38	547	53
Adjustments	46	273	247	88	182	229	136	18	131	159	70	1,579	154
All Others	2,318	4,272	5,473	5,390	2,852	3,459	4,275	948	4,980	3,364	2,417	39,748	3,878
All Adjustments	890	2,902	4,389	4,140	1,629	1,463	1,774	341	2,423	2,082	†	*22,023‡*	*2,382*
Non Immigrant Physicians													
Total Admitted	5,365	5,191	4,283	5,166	5,517	3,466	3,243	893	2,141	1,169	†	*36,434*	*3,939*
Distinguished Merit and Ability	83	178	231	350	578	426	542	167	455	180	†	*3,169*	*343*
Trainees	174	173	82	178	149	143	77	37	65	20	†	*1,141*	*123*
Exchange Visitors	5,008	4,784	3,935	4,613	4,717	2,849	2,562	674	1,578	951	†	*31,671*	*3,424*
Transferees	—	9	10	25	73	48	62	15	43	18	†	*303*	*33*
Other Temporary	100	47	25	—	—	—	—	—	—	—	†	*172*	*19*
Net "Physician Entries"	7,633	8,045	7,038	8,145	8,425	7,364	7,653	1,857	6,791	3,522	†	*66,482*	*7,187*

*For Fiscal Years 1970-76, each year terminated as of June 30 of the respective year; The Transitional Quarter (T.Q.) 1976 commenced July 1 and terminated September 30 of that year; FY 1977-FY 1979 comprised the twelve months ending on September 30 of those years.

†Data not yet published or available.

‡Data in italics are for the 9¼ year interval, July 1, 1969 through September 30, 1978.

Sources: Tables 8A and 16B, Annual Reports 1970-1977, Immigration and Naturalization Service, U.S. Department of Justice; Data for FY 1978 and FY 1979 were supplied by the Statistical Analysis Branch, INS; Total Physician Adjustments for each year were derived from unpublished special tabulations on Immigrant Scientists and Engineers in the U.S. prepared from INS data by the National Science Foundation; Net "Physician Entries" have been calculated by the summing of immigrant and non-immigrant physicians each year and subtracting from the total the number of all adjustments effected that year.

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convert his temporary visa to an immigrant visa were markedly simplified; since the presentation of a valid visa is considered as an "entry" those granted first a temporary and subsequently a permanent visa are subject to duplicate counting. These adjustments and their impact on the total number of physicians in the U.S. will be considered in greater detail below. Suffice it to say Title VI of PL 94-484 and the additional amendments to the Immigration and Nationality Act included in PL 95-83, were intended to reduce substantially the number of physicians entering the U.S. for the first time in either category. An additional objective was to revert to the situation when an exchange visitor could not remain in the U.S. and "adjust" to a permanent visa. A temporary visitor must, again, leave this country and remain in his own country for at least two years before applying for an immigration visa.

Such more stringent requirements have been implemented in a manner designed to avoid personal hardship to those individuals already in the U.S. or whose visas were already authorized and, also, to minimize the disruption of hospital training programs accepting FMGs for residency or other graduate educational experience. The initial effect of these changes in the law and the accompanying alterations in administrative regulations are only beginning to be reflected in the data at present available. The ultimate effect may only become apparent when all relevant data for FY 1979 and for subsequent years are published.*

As reported in analyses published earlier, the number of immigrant physicians entering the U.S. rose steadily over the post-World War II years to reach the level of approximately 3,000 per year by FY 1970. Then, as shown in Table 7, with the stimulation provided by PL 91-225 which encouraged temporary visitor physicians to convert their visas, the number of immigrant physicians more than doubled and exceeded 7,000 in both FY 1972 and FY 1973. Over 60 percent of the immigrant physicians admitted in those two years had already been in the U.S. for some time in temporary visitor status and became permanent residents by "adjustment." Examining the data appearing in Table 7 for FY 1970 through FY 1979 it becomes evident that the number of immigrant visas issued to physicians has continued at high levels; only in FY 1974 and more recently in FY 1978 and in FY 1979 has the number of new permanent resident FMGs fallen below 5,000 per annum. The average number of FMGs entering the U.S. as immigrants each year during the full 10¼ year interval displayed in this table is 5,376.**

Table 7 also shows that, in the non-immigrant category, substantial declines in the number of total admissions, and particularly for physicians admitted as exchange visitors (J visa), are discernible as early as FY 1975. It is possible that this alteration in trend can be attributed to an administrative rearrangement within the Bureau of Educational and Cultural Affairs of the State Department initiated early in FY 1973 to provide greater overall controls as well as programmatic supervision of all the FMGs coming to the U.S. for graduate medical education on an exchange visitor visa (EVFMGs). This initiative undertaken first with the temporary Commission on Foreign Medical Graduates did not become fully operational until the beginning of FY 1974 when by formal agreement with the State Department, ECFMG became the sole sponsoring agency for all such exchange visitor physicians.

In FY 1977 this downward trend became more pronounced, reaching 2,141 for all non-immigrant physicians and 1,578 for exchange visitor physicians. In FY 1978, the most recent year for which INS data have as yet been published, the total number of non-immigrant physicians fell to 1,169 and exchange visitor physicians to 951. Available

*Available data for FY 1979 (ending as of September 30 of that year) do not include physicians admitted on temporary visitor or other non-immigrant visas; they do indicate, however, that the total number of immigrant physicians that year had declined to approximately 3,000 (see Table 7).

**An element of this table that may complicate its interpretation is the introduction of an additional column for the transitional quarter between FY 1976 and FY 1977 when, by Act of Congress, the termination of the fiscal year of Federal Government operations was changed from June 30 to September 30. During the transitional three months in 1976, immigration visas were issued to physicians at or slightly below the rate recorded during the preceding 12-month period. The upward fillip to the 7,000 level that followed in FY 1977 can be attributed to two possible intervening factors: the "grandfather clause" permitting adjustment of temporary to permanent visas by physicians already in the U.S. when PL 94-484 took effect and secondly, a provision allowing a substantial number of physicians to enter the U.S. who had already met all other admission requirements then in effect, had already applied for admission on a permanent visa and who were only awaiting the issuance of a valid admission number within the numerical limitations permitted by law for each country of origin.

records indicate that these diminishing numbers of FMGs entering this country for the first time as temporary visitors are the lowest for any year since the Fulbright-Hays Act of 1961 established the ground rules for all exchange visitor programs and provided formal sponsorship for alien physicians seeking temporary access to graduate medical training opportunities in U.S. hospitals.

The marked reduction in the number of non-immigrant FMGs in FY 1977 and FY 1978 can be ascribed only fractionally to the more demanding requirements of Title VI of PL 94-484. Although some of the requirements took effect in January 1977, the Visa Qualifying Examination, for example, was not in place until September 1977 and its results became available only when FY 1978 was already underway. It is possible, on the other hand, that the number of applications for temporary visas submitted by alien physicians diminished promptly with the enactment of the legislation. Many FMGs may have then recognized, even before setting foot on American soil, that a climate favoring their migration to the U.S. no longer prevailed. Thus the rescinding of privileges FMGs had learned to expect may have created psychological deterrents not foreseen by Congressional staff drafting the amending legislation.

As noted above, the actual number of FMGs migrating to the U.S., as reported by the Immigration and Naturalization Service, may have been overestimated. The data incorporated in Table 7 permit an appropriate correction of the duplicate counting of those alien physicians who were granted an immigration visa between July 1, 1968 and September 30, 1978, and who were known to have "adjusted" from a non-immigrant visa issued to them during that same interval or even earlier. Such "adjustments" are listed for each of the fiscal years included in the table. "Net physician entries" for these same years have been calculated by subtracting the number of "adjustments" from the sum of immigrant and non-immigrant visas issued in any given year. When such a procedure is followed it is of interest that over the period covered by Table 7 the average number of "net physician entries" per year amounted to 7,187 with only relatively slight interannual variation, with the exception of the most recent year, FY 1978, when this number declined sharply to 3,522. For the 9¼ year period covered by data included in the table, there were, in total, 66,482 "net physician entries" into the U.S.; had the former pattern of counting been followed — simply adding the numbers of immigrant and non-immigrant visas issued — it would have been concluded that during this interval 88,466 FMGs had been added to our physician supply, an overcount of 22,024 or 33 percent.

The geographic origins of FMGs coming to the U.S. based on the region and country of their birth, has been subject to considerable variation over the period of the past ten years. These variations are reflected in the three following tables which pro-

TABLE 8-A

FOREIGN-BORN PHYSICIANS ADMITTED TO THE UNITED STATES AS IMMIGRANTS, ACCORDING TO REGIONAL AREAS OF BIRTH, FY 1968, FY 1973 AND FY 1978

Regions	1968		1973		1978	
	N	%	N	%	N	%
All Regions	*3,060*	*100.0*	*7,097*	*100.0*	*4,435*	*100.0*
Europe	*694*	*22.7*	*732*	*10.3*	*546*	*12.3*
Western Europe	423	13.8	384	5.4	280	6.3
Eastern Europe	271	8.9	348	4.9	266	6.0
N. and C. America	*596*	*19.5*	*335*	*4.7*	*960*	*21.6*
South America	*336*	*11.0*	*263*	*3.7*	*351*	*7.9*
Asia	*1,307*	*42.7*	*5,392*	*76.0*	*2,330*	*52.5*
Near East	184	6.0	623	8.8	214	4.8
Far East	1,123	36.7	4,769	67.2	2,116	47.7
All Other Regions	*117*	*3.8*	*375*	*5.3*	*248*	*5.6*
Africa	113	3.7	321	4.5	220	5.0
Other	4	0.1	54	0.8	28	0.6

Sources: Immigration and Naturalization Service, U.S. Department of Justice; and the Division of Science Resources Studies, National Science Foundation.

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vide data for alien physicians admitted to the U.S. as immigrants; regrettably, similar data for foreign-born physicians entering the U.S. on temporary visas are not as readily available. Obviously, close similarities exist between the nationalities and/or nativity of immigrant and exchange visitor physicians coming to the U.S. As will be discussed below, as many as two out of five immigrant physicians in recent years established permanent residence in the U.S. as a culmination of a prior admission to this country on a temporary visa granted to them for the limited purpose of obtaining graduate medical education in a hospital training program.

Table 8-A shows the number of alien physicians admitted to the U.S. as immigrants in three selected years, 1968, 1973 and 1978, according to broad regional areas of birth. It may be noted that for all regions the total number of immigrant physicians rose from 3,060 in 1968 to 7,097 in 1973; in 1978, the total had declined to 4,435. For Europe, the Americas, the Near East, Africa and for all other areas excepting Far East Asia, there have been only minor variations in the actual numbers of immigrant physicians in each of the three selected years. For the Far East Asia region, however, the number of immigrant alien physicians rose from 1,123 in 1968 to 4,769 in 1973 and more recently, in 1978, has declined to 2,330. As percentages of the total number of foreign-born immigrant physicians, those native to Far East Asia rose from 36.7 percent in 1968 to 67.2 percent in 1973 and receded to 47.7 percent in 1978.

A more precise identification of places of birth of immigrant physicians admitted to the U.S. in each of the same three selected years, 1968, 1973 and 1978, listing the 15 leading native countries of these immigrant FMGs is provided in Table 8-B. In 1968, except for the Philippines and Cuba, there were relatively modest inter-country variations in the number of immigrant alien physicians; a much wider range of variation may be noted both in 1973 and in 1978. For the Philippines, the number of native physicians migrating permanently to the U.S. does not vary appreciably in the three selected years included in this table. For Indian native physicians, on the other hand, there was more than a fourteen-fold increase from 134 in 1968 to 1,921 in 1973 with a subsequent decline to 684 in 1978.

By selecting data for non-sequential years as was done in Table 8-B, some of the interannual variations that do occur may be obscured. To illustrate such phenomena Table 8-C has also been included in this presentation. This tabulation provides data for a large number of individual countries grouped

TABLE 8-B

FOREIGN-BORN PHYSICIANS ADMITTED TO THE UNITED STATES AS IMMIGRANTS; THE 15 LEADING COUNTRIES OF BIRTH, FY 1968, FY 1973 AND FY 1978

1968			1973			1978		
Country	*N.*	*%*	*Country*	*N.*	*%*	*Country*	*N.*	*%*
1. Philippines	703	23.0	1. India	1,921	27.1	1. India	684	15.4
2. Cuba	288	9.4	2. Philippines	753	10.6	2. Philippines	602	13.6
3. India	134	4.4	3. Korea	610	8.6	3. Canada	449	10.1
4. Colombia	115	3.8	4. Iran	359	5.1	4. China (PRC)	158	3.6
5. Iran	112	3.7	5. Taiwan	308	4.3	5. United Kingdom	115	2.6
6. United Kingdom	111	3.6	6. Thailand	307	4.3	6. Mexico	99	2.2
7. Canada	105	3.4	7. Pakistan	292	4.1	7. Cuba	95	2.1
8. Argentina	92	3.0	8. China (PRC)	235	3.3	8. Argentina	93	2.1
9. Poland	85	2.8	9. United Kingdom	103	1.5	9. Korea	88	2.0
10. Korea	73	2.4	10. Canada	95	1.3	10. Chile	67	1.5
11. W. Germany	68	2.2	11. W. Germany	78	1.1	11. Pakistan	66	1.5
12. Turkey	58	1.9	12. Cuba	73	1.0	12. Iran	65	1.5
13. China (PRC)	53	1.7	12. Greece	73	1.0	13. Peru	63	1.4
14. Ecuador	43	1.4	12. Syria	73	1.0	14. Taiwan	51	1.1
15. Mexico	42	1.4	13. Colombia	66	0.9	15. Poland	43	1.0
			14. Japan	64	0.9			
			15. Poland	56	0.8			
All Other	978	31.9	All Other	1,631	23.1	All Other	1,697	38.3
Total	3,060	100.0	Total	7,097	100.0	Total	4,435	100.0

Sources: Immigration and Naturalization Service, U.S. Department of Justice; and Division of Science Resources Studies, National Science Foundation.

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TABLE 8-C

PHYSICIANS ADMITTED TO THE U.S. AS IMMIGRANTS BY COUNTRY/REGION OF BIRTH, FY1973-FY1978

Country/Region	*1973*	*1974*	*1975*	*1976*	*T.Q. 1976*	*1977*	*1978*
Totals	*7,097*	*4,537*	*5,361*	*6,184*	*1,305*	*7,073*	*4,435*
Europe	*732*	*477*	*627*	*707*	*204*	*737*	*546*
Austria	7	6	6	5	3	4	6
Belgium	14	2	20	6	1	9	7
Denmark	9	2	5	7	2	5	2
France	16	7	10	6	5	24	16
W. Germany	78	46	58	55	9	38	41
Greece	73	36	56	41	11	45	30
Ireland	39	26	32	37	14	37	23
Italy	26	26	17	18	7	31	24
Netherlands	4	7	4	6	2	13	5
Norway	2	5	1	4	1	5	3
Poland	56	41	35	43	11	40	43
Spain	53	35	31	26	6	20	14
Sweden	7	5	10	3	2	5	2
Switzerland	13	9	9	10	2	9	10
Turkey	51	25	20	17	11	19	17
United Kingdom	103	82	117	154	53	194	115
Other E. Europe	168	109	178	244	59	219	176
Other Europe	13	8	18	25	5	20	12
N. & C. America	*335*	*294*	*334*	*404*	*110*	*922*	*960*
Canada	95	69	84	86	31	325	449
Mexico	49	47	53	69	21	94	99
Cuba	73	52	67	104	18	231	95
All Other	118	126	130	145	40	272	317
South America	*263*	*186*	*291*	*334*	*77*	*369*	*351*
Argentina	46	43	82	111	24	110	93
Bolivia	22	5	13	13	2	16	15
Brazil	15	11	17	19	2	30	17
Chile	26	22	23	25	10	26	67
Colombia	66	34	62	44	10	43	39
Ecuador	13	9	9	13	2	13	19
Peru	49	45	61	68	15	66	63
Venezuela	9	3	5	12	3	17	10
Other	17	14	19	29	9	48	28
Asia	*5,392*	*3,334*	*3,781*	*4,341*	*841*	*4,389*	*2,330*
Near & M. East	623	347	329	380	107	462	214
Iran	359	123	106	58	14	106	65
Iraq	36	33	11	16	2	33	20
Lebanon	29	38	44	93	40	110	37
Other	154	116	140	172	43	158	69
Far East	4,769	2,987	3,452	3,961	734	3,927	2,116
Hong Kong	21	8	15	16	5	27	27
China	235	161	170	143	69	216	158
India	1,921	1,276	1,709	2,038	363	2,046	684
Japan	64	41	32	37	7	26	12
Korea	610	311	361	240	55	140	88
Pakistan	292	161	221	234	37	200	66
Philippines	753	575	570	899	119	763	602
Thailand	307	182	89	107	19	150	58
Taiwan	308	84	98	65	13	78	51
Other Far East	258	188	195	182	47	281	370
Africa	*321*	*206*	*284*	*334*	*77*	*369*	*351*
All Other	*54*	*40*	*44*	*64*	*15*	*58*	*28*

Sources: Immigration and Naturalization Service, U.S. Department of Justice; and Division of Science Resources Studies, National Science Foundation.

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by geographic regions and for each of the separate fiscal periods, FY 1973 to FY 1978. Note here, for example, how Canada has altered its position in recent years as a source of physicians taking up permanent residence in the U.S. In the two most recent years, FY 1977 and FY 1978 there has been a surge from less than 100 emigrating physicians to the U.S. to 325 and 449 respectively.

Additional previously unpublished INS data on the admission of physicians to the U.S. either as immigrants or temporary visitors have recently been made available by the National Science Foundation. These provide insights into the patterns followed by FMGs in converting their visas from temporary visitors to permanent residents. These data are presented in Table 9 and permit the correlation of the number of physicians who adjusted from a temporary to a permanent visa in each of the years since FY 1966 with the fraction of that total who entered this country on a temporary visa in each of the preceding years. Records of the total number of exchange visitor visas issued to physicians have been maintained since FY 1962 and for all temporary visas issued to physicians only since FY 1966. Regrettably, no records have been kept of the number of physicians granted a temporary visa who have left the U.S. and returned to their country of origin.

Up to September 30, 1978, no less than 74,416 temporary visas to enter the U.S. are known to have been issued to alien physicians. In the interval covered by this table, from July 1, 1965 through September 30, 1978, a total of 24,576 physicians who entered this country on temporary visas subse-

TABLE 9
FOREIGN MEDICAL GRADUATES WHO HAVE "ADJUSTED" FROM TEMPORARY VISITORS TO PERMANENT RESIDENTS
FY 1966-FY 1978

Year of 1st Entry to U.S.	*Temp. Visas Issued to Physicians*	*Year of "Adjustment" from Temporary to Immigrant Visa* 1966	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976	T.Q. 1976	1977	1978	*Temporary Visas "Adjusted" to 9-30-78* No.	%
<1955	n.a.	12	21	9	5	1	3	16	7	3	—	—	—	—	78	155	
1955	n.a.	12	8	1	3	2	4	1	—	—	1	—	—	1	—	33	
1956	n.a.	18	17	7	7	3	2	1	—	—	—	—	—	—	—	55	
1957	n.a.	22	47	19	5	11	7	7	2	—	—	—	—	1	—	121	
1958	n.a.	54	66	14	10	12	12	7	2	1	—	—	—	—	1	185	
1959	n.a.	55	87	34	14	21	20	4	4	3	1	2	—	3	1	249	
1960	n.a.	30	50	22	23	19	14	7	2	2	1	—	—	—	1	171	
1961	n.a.	30	66	40	35	20	20	8	3	5	1	2	—	2	—	232	
1962	3,930*	52	84	76	66	71	82	33	8	3	5	3	—	6	3	492	12.5
1963	4,637*	59	70	71	90	107	152	71	29	20	17	10	5	20	17	738	15.9
1964	4,518*	63	143	47	63	145	277	96	54	23	8	66	5	58	21	1,069	23.7
1965	4,160*	64	116	108	45	72	313	158	35	16	12	83	7	70	32	1,131	27.2
1966	4,370*	3	66	152	73	84	412	322	55	24	13	92	4	66	40	1,406	32.2
1967	5,571		—	51	72	103	513	551	112	17	24	65	2	35	30	1,575	28.3
1968	5,997			1	59	132	410	681	236	45	20	47	6	45	41	1,723	28.7
1969	4,759				—	86	375	684	391	100	43	38	6	39	40	1,802	37.9
1970	5,365					1	236	923	660	175	118	85	7	54	37	2,296	42.8
1971	5,191						50	757	1,367	375	213	163	29	94	58	3,106	59.8
1972	4,283							62	1,135	459	245	250	53	275	98	2,577	60.2
1973	5,166								38	343	460	262	60	354	181	1,698	32.8
1974	5,517									15	266	427	75	465	231	1,479	26.8
1975	3,466										15	178	77	501	546	1,317	38.0
1976	3,283											1	5	282	362		
TQ1976	893															650	15.6
1977	2,141													52	264	316	14.8
1978	1,169																
Totals	74,416	474	841	652	576	890	2,902	4,389	4,140	1,629	1,463	1,774	341	2,423	2,082	24,576	33.0

n.a. Data Not Available.
*Exchange Visitor Visas Only; Data for Other Temporary Visas Not Available.
Sources: Annual Reports, Immigration and Naturalization Service, U.S. Department of Justice; Unpublished Data, National Science Foundation.
T.D.D./Revised 5-6-80

quently adjusted. It is possible that due to the incompleteness of the data incorporated in this table the total number of temporary visitor physicians is, in actuality, larger than the 74,416 who have been so identified. If such is the case, the calculated "adjustment" rate of 33.0 percent may overstate the true fraction of the total who came to visit but remained in permanent residence.

Nevertheless, this tabulation does indicate that for certain years, specifically, for FY 1971 and FY 1972, 60 percent of the temporary visitor physicians admitted in those two years were subsequently issued a permanent resident visa, 59.8 percent in FY 1971 and 60.2 percent in FY 1972. It may be recalled that PL 91-225, enacted in 1970, facilitated such adjustments and, in all probability, accounted for the sharp increase in the total number of adjustments from 890 in FY 1970 to 1,902 in FY 1971; immediately thereafter, in FY 1972, this number peaked at 4,389 and declined only slightly to 4,140 in FY 1973. In the two most recent years for which data are currently available, FY 1977 and FY 1978, the number of adjustments to permanent visas remain high, 2,423 in the former year and 2,082 in the latter. Although PL 94-484 called a halt to this privilege to physicians as of January 1977, a "grandfather clause" allows those physicians who were already in the U.S. on temporary visas, to exercise this option should they wish to do so. The sizeable number of adjustments continuing to take place in FY 1977 and FY 1978 reflects this situation.

Also to be noted in Table 9 is the time interval that may elapse between the year of initial entry to the U.S. on a temporary visa and the year in which adjustment actually took place; in a few instances this lag extended to 23 or more years. For the total group of "adjusters" included in this tabulation, the median number of years between initial entry to the U.S. and the year of adjustment was seven. For those who have come to the U.S. since FY 1972 and have since adjusted, half had received their permanent resident visas within three years following their initial entry.

Twenty-four thousand five hundred seventy-six alien physicians who initially entered the U.S. on a non-immigrant visa are known to have converted their visitor visas to one permitting permanent residence in this country. During the same interval, INS records indicate that a total of 59,395 immigration visas were issued to alien physicians. Thus, of all alien physicians immigrating to the U.S. during this period, whether on a family preference, an occupational or nonpreference visa, 37.9 percent, or two out of every five, did so as the culminating event in an antecedent "temporary" visit. For the most part these visitors came to the U.S. from underdeveloped countries of the world as participants in a program originally undertaken as a means of international educational and cultural exchange; a small fraction of the total were considered to be of distinguished merit and ability.

E. ON ECFMG OPERATIONAL EXPERIENCE

The two tables reviewed in this section of the report, Tables 10 and 11-A, add to the quantitative data reviewed above the experience gathered by the Educational Commission for Foreign Medical Graduates during the twelve-year period up to and including calendar year 1980. It may be observed in the first two columns of Table 10 that the number of applications received and the number accepted for registration peaked in 1975, thereby reinforcing the other evidence presented that a significant change in trend has taken place in recent years. Additional substantiation is also provided to the observation that this alteration in trend preceded both the publication of the CCME 1976 report or the passage of PL 94-484 the latter designed to curtail drastically the ease with which either temporary or permanent entrance visas could be acquired by FMGs. The declines in the three following years, 1976-78, in the number of applications received and the number of applications registered, 44 percent and 45.5 percent respectively, appear to have accelerated between 1977 and 1978. Thus, awareness of the new proscriptions added to the Immigration and Nationality Act may also have dampened the determination of some FMGs to qualify for admission to the U.S. The reversal of this downward trend in 1979 reinforced by further increases in 1980 suggest that restraints imposed by U.S. immigration provision will not of themselves resolve all of the issues affecting the involvement of FMGs in American medicine.

The number of candidates examined by ECFMG and the number of candidates appearing for their initial ECFMG examination also peaked in 1975. However, one year earlier, in 1974, the number of candidates successfully completing the ECFMG examination process, either on a first sitting or after multiple attempts, reached 15,225, the highest level for any one year. Here again U-shaped trends are observed with 1978 providing low points in the

number of candidates examined as well as in the number passing ECFMG examinations. The resumption of upward movement may not be quite as marked in these categories of ECFMG operating activity, and yet there is little reason to anticipate a further loss of the ECFMG's FMG constituency. The differences in the numbers in the columns for successful examinees, eligibles for ECFMG certification, and standard certificates issued, deserve further explanation.

Eligibility for certification includes, in addition to full documentation of medical education and successful completion of both the medical competence examination and the modified Test of English as a Foreign Language (TOEFL), documentation of the candidate's eligibility to practice medicine in the country in which he acquired his medical degree; furthermore, a standard certificate will not be issued until the candidate has cleared his ECFMG financial account.

From the above discussion it can be inferred that the numbers appearing for each of the years listed in the "Newly Eligible" column represent additions to the total cohort of individuals who have satisfied all of the requirements for ECFMG certification regardless of their reason for taking ECFMG examinations or whether they have come to the U.S. or remain in their country of origin. For example, it has been reported that in some countries medical school authorities recommend or may even require that their graduating students sit for an ECFMG examination; the results may be used to compare their educational program and its effectiveness with the programs in other schools or other countries. Some candidates may apply for ECFMG certification without an established plan to seek graduate medical educational experience in the U.S. Some candidates apply for ECFMG certification as a form of professional insurance, believing that at some future date they may wish to obtain graduate medical training in or even migrate permanently to the U.S.; they may also believe that they may have a greater chance of success on the technical medical competence examination immediately or soon after completion of their medical school education than they would if they were to wait a number of years before seeking ECFMG certification.

The number of standard certificates issued in a given year is, in all probability, a sensitive indicator of the actual number of FMGs ready to start their graduate medical education in the U.S. In the twelve years covered by this tabulation, the number of standard certificates issued in any specific year has not fluctuated through too wide a range around the mean of just under 6,300 per year; a high of 8,712 occurred in 1972 and the low of 4,686 was observed in 1969. It may be noted that a decline occurred from 6,997 standard certificates issued in

TABLE 10

EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES OPERATIONAL ACTIVITY FOR THE TWELVE YEARS 1969-1980

			Applicants Examined					*Applicants Passing Examination*					*ECFMG Certification*		*Exchange Visitor Sponsorship Program*		
	Applications			*Full ECFMG Exam*		*Test of English*			*ECFMG Medicine Exam*		*Test of English*			*Standard*	*(Academic Year)*		
Year	*Received*	*Registered*	*Total*	*Initial*	*Repeat*	*Only*	*VQE*	*Total*	*Initial*	*Repeat*	*Only*	*VQE*	*Newly Eligible*	*Certificates Issued*	*Total*	*Initial*	*Cont.*
1969		26,258	23,126	12,447	10,151	528		8,398	6,348	1,779	271		3,767	4,686			
1970		36,390	30,578	16,631	13,319	628		12,279	8,888	3,034	357		5,046	5,436			
1971		38,290	31,662	16,525	14,508	629		10,103	7,608	2,085	410		3,894	6,886			
1972		40,281	32,814	15,556	16,516	742		13,318	8,228	4,609	481		5,860	8,712			
1973	49,507	46,227	37,853	18,699	18,338	816		12,766	8,982	3,307	477		5,094	6,227			
1974	53,971	50,079	38,366	19,711	17,736	919		15,225	10,522	4,346	357		5,436	7,579	8,458	2,791	5,667
1975	56,878	51,637	38,441	20,415	16,384	1,642		13,899	10,492	3,137	270		3,379	6,542	7,507	2,477	5,030
1976	49,746	42,019	32,886	16,799	12,684	3,403		14,214	10,192	3,538	484		2,680	6,997	7,450	2,458	4,992
1977	52,155	42,465	34,422	14,041	11,830	3,940	4,611	10,421	6,708	1,894	656	1,163	2,546	6,636	5,310	1,308	4,002
1978	31,853	28,150	23,744	7,735	9,288	3,504	3,217	7,671	3,785	1,941	1,000	945	2,089	4,966	3,660	959	2,701
1979	35,538	32,260	28,962	8,617	9,053	6,502	4,790	11,445	4,471	2,301	3,236	1,437	3,128	4,817	2,557	413	2,144
1980	39,204	35,322	32,029	10,599	10,049	6,425	4,956	11,959	5,113	2,419	3,203	1,224	3,065	5,756	2,020	477	1,543

ECFMG Certification Total Eligible — Passers who had met credential requirements and had a clear ECFMG financial account at the time of results.

ECFMG Certification Standard Certificates Issued — Includes percentage of Total Eligible plus applicants who had previously met all requirements, but delayed obtaining certificates.

Exchange Visitor Sponsorship Program — Exchange Visitor Foreign Medical Graduates under ECFMG sponsorship for clinical training in a graduate medical education program. Figures reflect academic year July 1 through June 30. Initial designates applicants in first year of sponsorship.

1976 and 6,636 in 1977 to 4,966 in 1978 and 4,817 in 1979. The reversal of this trend with a rise to 5,756 standard certificates issued in 1980, is consistent with the recently heightened application activity and increased number of examinees referred to above and may have some special significance. Whether this is so or not will only be discernible when additional comparable information becomes available for 1981 and later years.

The data listed in the final three columns of Table 10 also warrant special attention because they represent, along with the listed results of the Visa Qualifying Examination (VQE), new administrative functions assigned to and accepted by the ECFMG. With the passage of time they may prove to be more sensitive indicators than have heretofore been available of the utility and effectiveness of national programs instituted to meet the special needs of FMGs or to surmount the problems arising from their participation in graduate medical education programs in this country.

For purposes of orientation, the Exchange Visitor Sponsorship Program was initiated by the Bureau of Educational and Cultural Affairs of the State Department in the summer of 1972 when that agency recognized that its own limited resources made it almost impossible to keep track of the large number of exchange visitor physicians in the U.S. for whom it held responsibility. It then asked the Commission on Foreign Medical Graduates to serve as overall sponsor for alien physicians involved in this program and to establish a record system permitting a higher level of accountability for their progress toward definable educational goals. With the merger of the Commission and the Educational Council to form the Educational Commission for Foreign Medical Graduates in June, 1974, this delegation was extended first by a new agreement made by the State Department and more recently by the U.S. International Communication Agency. Current, detailed and computerized records are now available for every sponsored trainee, permitting ongoing assessments of where these FMGs are located and the exact nature of the training being undertaken. New entries, transfers from one program to another, the completion of training or other forms of termination are also recorded. However, all FMGs are not so carefully monitored; U.S. nationals who received their medical degrees abroad and, more particularly, FMGs entering the U.S. initially on an immigrant visa or who have been able to change from a "J" or "H" visa to an immigrant visa do not come within the purview of this Sponsorship Program or this extensive record system.

Note, in Table 10, that between the two academic or program years 1975-76 and 1976-77, the total number of EVFMGs (participants in the Exchange Visitor Sponsorship Program — see above) declined from 7,450 to 5,310; 1,150 of the loss occurred among "new" and the balance, 990, among the "continued" sponsored exchange visitors. Among the initial sponsorees the reduction in numbers approached 50 percent that year. In the following year the fall-off of EVFMGs continued so that in program year 1977-78 the total number was down to 3,660 and the "initial" and "continued" to 959 and 2,701 respectively. Because PL 94-484 was not enacted until program year 1976-77 was already in progress and then did not affect the requisite qualifications for alien physicians seeking an exchange visitor visa until midway in the following program year, 1977-78, one must seek elsewhere to find an appropriate explanation for these developments in the Exchange Visitor Sponsorship Program.

It is possible, for example, that one or more factors only indirectly related to changes in the Immigration and Nationality Act may be implicated. Among those coming to mind is the more stringent test of a candidate's command of English as a spoken language (modified TOEFL) introduced by the ECFMG in 1974 as an essential requisite to certification. Even before then a small number of candidates had been required to repeat the less discriminating language component of the ECFMG examination and some of them could not satisfy that requirement. In the last few years the number of candidates failing the test of English has increased remarkably and the proportion continuing to fail such a test has increased similarly. Notable, also is the fact that since January 1979 an acceptable performance on the TOEFL remains valid for only two years. This and the English language requisite of the Visa Qualifying Examination (VQE), mandated since 1977 by PL 94-484, may bring about further increases in the numbers of takers of the modified TOEFL.

Another possibility is that the abridgment of the privilege of adjustment, also mandated by PL 94-484, may have prompted some exchange visitors already in this country to exercise that option while it was still available to them. This factor could help to explain the decline in the number of continued EVFMGs for when a sponsored ECFMG adjusts to

an immigrant visa he automatically terminates his sponsorship status and his listing is deleted from the Program records. It is more difficult to attribute the decline in the number of initial sponsorees to the same "adjustment" factor. Could the Visa Qualifying Examination, first offered in September 1977 with an initial pass rate of approximately 25 percent, account for the observed shrinkage? Or, are these most recent reductions manifestations of a declining interest in an exchange program limited to two, or at most three, years of training, a period which may be too short to complete all phases of the desired specialized graduate medical education in the U.S.? By the end of the 1979-80 operational year the overall total number of participants in the EVFMG program had declined to 2,020, less than one-quarter the number of participants 6 years earlier. Initial participants fell to 413 in 1978-79 its lowest point and less than one-sixth of the number of the FMGs starting this exchange program six years earlier in 1973-74. In the program year just completed, 1979-80, the number of initial participants has risen slightly to 477 but the number of continuing participants has fallen further to 1,543.

Table 11-A, also based on ECFMG data, provides insights into some of the changing patterns of ECFMG examination experience during the six years, 1975-80. Particular attention has been directed in this analysis to identifying the impact the enactment of PL 94-484 has had on the number of candidates taking ECFMG examinations, the number of initial or repeat examinations given, the passing rates achieved by different groups of candidates and examination experience in domestic centers compared with those in examination centers abroad. Keeping in mind that PL 94-484 was enacted in October 1976 and in order to differentiate clearly between circumstances prevailing before and after that salient event, comparisons have been made between average per examination experience during the two-year interval, 1975-76, and similar experience in the two most recent years, 1979-80.

It may be noted in the top section of the tabula-

TABLE 11-A
ECFMG EXAMINATION EXPERIENCE
1975-1980

Candidates Per Examination

Site and/or Type of Examination	*1975-1980* Average Number Examined	*1975-1980* Average Number Passing	*1975-1980* Percent Passing	*1975-1976* Average Number Examined	*1975-1976* Average Number Passing	*1975-1976* Percent Passing	*1979-1980* Average Number Examined	*1979-1980* Average Number Passing	*1979-1980* Percent Passing
All Examination Centers	12,290	4,666	38.0	16,571	6,840	41.3	9,576	3,576	37.3
Domestic Centers	4,528	1,254	27.7	4,519	1,236	27.4	4,831	1,517	31.4
Initial Examinations	1,220	482	39.5	1,108	429	38.7	1,512	650	43.0
Repeat Examinations	3,308	772	23.3	3,411	808	23.7	3,320	867	26.1
Centers Abroad	7,762	3,412	44.0	12,051	5,604	46.5	4,745	2,059	43.4
Initial Examinations	5,297	2,915	55.0	8,196	4,743	57.9	3,291	1,746	53.1
Repeat Examinations	2,466	498	20.2	3,856	861	22.3	1,454	313	21.5
All Initial Examinations	6,517	3,397	52.1	9,304	5,172	55.6	4,803	2,396	49.9
All Repeat Examinations	5,773	1,269	22.0	7,267	1,669	23.0	4,774	1,180	24.7

Changes 1975-1976 to 1979-1980

Site and/or Type of Examination	*Average Number Examined*	*Percent*	*Average Number Passing*	*Percent*
All Examination Centers	−6,995	−42.2	−3,264	−47.7
Domestic Centers	+ 312	+ 6.9	+ 281	+22.7
Initial Examinations	+ 404	+36.5	+ 221	+51.7
Repeat Examinations	− 91	− 2.7	+ 59	+ 7.3
Centers Abroad	−7,306	−60.6	−3,545	−63.3
Initial Examinations	−4,905	−59.8	−2,997	−63.2
Repeat Examinations	−2,402	−62.3	− 548	−63.6
All Initial Examinations	−4,501	−48.4	−2,776	−53.7
All Repeat Examinations	−2,493	−34.3	− 489	−29.3

Sources: National Board of Medical Examiners Tabulations of Applicant Status and Pass Rates for ECFMG Examinations #44 through #55.

T.D.D./Revised 1-30-81.

tion that for the entire six-year period, 1975-80, almost 12,300 candidates, on the average, were examined in each of the twelve separate examinations given. During this interval, approximately two out of three candidates were examined abroad and slightly more than half of all candidates were sitting for their first examination. Moreover, while over two-thirds of the candidates examined abroad (5,297/7,762) were making their first attempt to gain ECFMG certification, three-quarters of the candidates being examined in domestic centers (3,308/4,528) were taking the ECFMG examination for a second or subsequent time. Whereas 38 percent of all candidates examined during the six-year period achieved a passing score, candidates taking the examination for the first time, and especially those doing so abroad, performed better as a group (52 percent and 55 percent respectively) than did candidates in domestic centers (28 percent) and significantly better than did repeaters (22 percent) regardless of where those candidates were examined for a second or subsequent time.

Comparing experience before and after enactment of PL 94-484, a number of remarkable differences become evident. In the 1975-76 interval almost 16,600 candidates were examined, on the average, in each of the four examinations given during those two years; during the two most recent years, 1979-80, the number of candidates examined, on the average, in each of the four examinations held fell to 9,576, a decline of 42 percent. Moreover, this decline occurred almost entirely in the number of candidates appearing at examination centers abroad. In the earlier period, 12,051 candidates were examined, on the average, in each of the examination sessions conducted abroad whereas, more recently, only 4,745 such candidates appeared per examination, a decline of 61 percent. In contrast, the number of candidates examined in domestic centers has risen slightly from 4,519 examined per examination in the earlier period to 4,831 per examination in the latter.

The decline in the number of candidates examined in the most recent, as compared to the earlier, time interval is particularly concentrated among initial examinees; the decline among all initial examinees is 48 percent with an even greater decline of 60 percent occurring among initial examinees abroad. Initial examinees tested in domestic centers actually increased on the average in each of the four examinations given in 1979-80, compared with those given in 1975-76, from 1,108 to 1,512, or 37 percent. A reduction in number also occurred among candidates appearing for a repeat examination (34 percent) and here again the fall in numbers was highly concentrated among candidates repeating the examination in centers located abroad (62 percent).

The passing rates in the two time intervals are not remarkably different. The decline observed — from a 41.3 to a 37.3 percent overall passing rate — may well be more a reflection of a larger proportion of all examinees in the more recent interval being repeaters than attributable to any other identifiable factor or factors. On the other hand, as a consequence of the reduction in the number of candidates examined in centers abroad, especially those examined for the first time, the actual number of candidates satisfying the examination requirements for ECFMG certification has diminished by 3,264 individuals, on the average, per examination, a striking reduction of 48 percent; the actual number of candidates, on the average, achieving a passing score per examination declined from 6,840 in the 1975-76 period to 3,576 in the 1979-80 interval. This decline was entirely concentrated in foreign examination centers where the average number of passing candidates fell from 5,604 per examination to 2,059 or 63 percent.

The data in Table 11-A clearly demonstrate a close association between the enactment of PL 94-484 and the significant reduction in the pool of alien physicians qualified to enter accredited graduate medical education programs in the U.S. This diminution is reflected in the number of new participants in the exchange visitor program for physicians (EVFMG Program) which has been declining from 2,458 in 1975-76 to 1,308 in 1976-77, 959 in 1977-78, 413 in 1978-79 and then rising slightly to 477 in 1979-80. Whether other factors not yet clearly identified may also be implicated in the reduction in size of the EVFMG Program is open to conjecture since the diminution of new participants seems to have antedated the enactment of PL 94-484. It is recognized, of course, that since the enactment of PL 94-484 an alien physician wishing to obtain such training must, as formerly, acquire ECFMG certification; in addition or in lieu thereof, he must now achieve a passing score on the newly devised VQE — an examination designed to be an even more rigorous test of an alien physician's scientific knowledge. This additional examination, however, may not be the sole operating factor.

U.S. NATIONALS STUDYING MEDICINE ABROAD

A MARKED INCREASE in the number of American nationals seeking to acquire a medical degree abroad has become the most vexing unresolved FMG issue confronting the American medical educational community (22-23, 10). The precise number of such students currently and actively studying medicine abroad is not known. As recently as 1971, however, it was estimated that the number of such expatriated U.S. students was approximately 2,000 (24); by 1973, this estimate was revised upward to the range of 4,000 to 6,000 with almost 1,800 studying in a single medical school in Mexico (25). Most recently, investigations utilizing multiple estimating techniques have placed the number of American medical students studying abroad (USFMS) at a minimum of 12,000 and possibly approaching 15,000 (26). Employing the lower estimate, the authors suggest that 80 percent of all U.S. medical students enrolled in foreign medical schools are now located in four countries: Mexico, Italy, the Dominican Republic and Spain, in that order, with one institution, the Autonomous University of Guadalajara, Mexico, accounting for 3,250 USFMS, or 27 percent of this aberrant student pool.

An additional insight into the expanding dimensions of this problem is provided by relevant ECFMG operational data. As shown in Table 11-B, the number of U.S. citizens taking ECFMG examinations each year has increased five-fold during the eleven years covered by this tabulation, from 824 in 1970 to 4,070 in 1980. The number of such candidates passing both the medical science and English language components has shown a parallel increase from 311 in the earlier year to 1,550 in the year just completed. Remarkably little variation from year to year has occurred in the proportion of U.S. national examinees who are successful in passing both parts of the ECFMG examination. Note, also, in the tabulation that during this recent span of years, U.S. nationals have increased from less than one in thirty-five of the 1970 takers or passers of ECFMG examinations to about one in five of all examinees and one in three of all successful candidates during this past year, 1980.

These increases in the number of USFMS have occurred despite the fact that the number of U.S. medical schools has increased since 1970 from 103 to 126. First year enrollment has climbed from 11,348 to 17,014 (56 percent) and total enrollment from 40,487 to 64,195 (59 percent) (27). Also of relevance are the recently published observations that the total pool of applicants to U.S. medical schools has decreased since its peak in 1974-75 of 42,624 to 36,141 in 1979-80; 45.1 percent of applicants to medical schools in 1978 were accepted by at least one LCME accredited institution, the highest acceptance rate since 1970 (28).

The paradoxical increased flow of U.S. students to medical schools abroad, especially to the mushrooming array of institutions in Central America and the Caribbean that appear to depend financially largely if not exclusively on American students, cannot be explained solely on the basis of massive number of highly qualified yet disappointed medical school applicants; a skillful and highly effective student recruiting program is being conducted by these schools and by commercial "placement" agencies (29).

Despite their impressive titles, such as the University of Dominica, Universidad Central del Este, American University of the Caribbean or St. George's University, few of these institutions are "Universities" in the customary meaning of that designation and none of the schools to which American students are now flocking are accredited by standards equivalent to those employed in the long-established procedures for the accreditation of U.S. and Canadian medical schools. All but a few of these recently launched extraterritorial medical schools are proprietary in nature, a system of medical education eliminated from the American scene in the second decade of the twentieth century as unsuitable and inappropriate to a learned profession. A highly informative and critical analysis of multiple efforts to create new medical schools in the British

TABLE 11-B

ECFMG EXAMINEES, 1970-1980

(Classified According to Citizenship at Time of Medical School Matriculation)

Year	U.S. Nationals			Foreign Nationals			% U.S. Nationals of Total Examinees	
	Total Takers	Passing Both Parts	Percent Passing	Total Takers	Passing Both Parts	Percent Passing	Takers	Passers
1970	824	311	37.7	29,126	11,604	39.8	2.8	2.6
1971	1,075	333	31.0	29,957	9,359	31.2	3.5	3.4
1972	1,298	472	36.4	30,772	12,365	40.2	4.0	3.7
1973	1,401	375	26.8	35,635	11,925	33.5	3.8	3.0
1974	1,709	610	35.7	35,738	14,258	39.9	4.6	4.1
1975	2,157	743	34.4	34,641	12,885	37.2	5.9	5.5
1976	2,159	871	40.3	27,279	12,847	47.1	7.3	6.3
1977	2,751	902	32.8	23,117	4,336	18.8	10.6	17.2
1978	2,896	1,020	35.2	14,127	2,344	16.6	17.0	30.3
1979	3,150	1,241	39.4	4,521	2,786	19.2	17.8	30.8
1980	4,070	1,550	38.1	16,578	3,115	18.8	19.7	33.2
11 Year Totals	23,490	8,428	35.9	291,491	97,824	33.6	7.5	7.9

Sources: *Results of ECFMG Examinations*, (Annual Publications, 1970-1980), Educational Commission for Foreign Medical Graduates, Philadelphia.

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Commonwealth Caribbean Countries, and especially eight concurrent proposals to establish offshore schools in the Bahamas for unsuccessful applicants to U.S. schools, has recently been published (30). The author, the chief medical officer of the Bahamian Ministry of Health, concluded that the justification of the promotional efforts was exclusively to generate profit for their initiators and would neither provide a proper educational experience for the prospective students nor have a rational role to play in meeting the immediate or future health needs of the populations residing in the communities where these schools might be located.

Incontrovertible evidence is accumulating to show that taken as a group, graduates of those schools accepting U.S. students in large numbers perform well below the levels of their U.S. trained counterparts, both on objective tests of cognitive knowledge and in the evaluation of their patient care skills (31-36). The long-range impact of this situation on the health and well-being of patients has not, as yet, been measured.

There are additional social and economic burdens imposed by what now appears to be a two-tiered system of medical education available to American nationals. Among those burdens of serious moment is the extraordinarily high student attrition rate found in the lower tier of the system. Based on the estimate of 12,000 plus U.S. nationals now enrolled in foreign medical schools — with at least two out of three of these enrolled in schools in Mexico or on Caribbean islands — Stimmel and Benenson suggested that as many as 2,400 of them should be completing their preparation for graduate residency training in U.S. hospitals each year (26). In all probability such a figure is much too high but, unfortunately, there are no reliable data available at the present time to establish what proportion of the aggregate number of Americans who start the study of medicine in a foreign medical school actually acquire a medical degree, obtain graduate residency training and, ultimately, gain the requisite license to engage in independent medical practice.

From a variety of anecdotal sources it is known that even within a few weeks or months after matriculating in many of these "offshore" programs, large numbers of expatriated medical students become so discouraged or disillusioned with the prospect of ever gaining their objective through this pathway that they voluntarily terminate their study of medicine. Also, as Weinberg and Bell noted a few years ago, "A minority of those enrolled in foreign medical schools are able to pass Part I of the NBME examination. Of these candidates (who do) not all are accepted for transfer. Certainly, not all of the remainder graduate from a foreign medical school. Of those who do graduate, a large number are unable to pass the ECFMG examination. And finally,

the FLEX examination for licensure is an insurmountable hurdle for some" (35). There are ample recent data substantiating such dour observations.

For example, the results of a new Medical Sciences Knowledge Profile Examination, an option available to U.S. nationals studying in foreign medical schools and seeking to transfer to a domestic school in lieu of the discontinued COTRANS program, are now available. About 40 percent of the first 1,601 examinees from foreign schools taking this examination in June 1980 failed to achieve the average score established for this composite test of students' knowledge in the sciences basic to medicine and in introductory clinical diagnosis; only eight percent of the students from U.S. schools sitting for the same examination failed to attain that average score. These results have led to the conclusion that "the efforts of these schools to recruit U.S. citizens are not matched by efforts to provide an adequate education" (37).

In addition, as shown in Table 12, over 4,000 American nationals attending some 224 medical schools in 56 countries outside of the U.S. and Canada were examined by the ECFMG in 1980, some for the second or greater time. Only 1,550 or 38 percent, obtained passing grades on both the medicine and the English language parts of the examination, prerequisites for appointment to a residency in an accredited hospital program (38).

An additional serious consideration is that the cost of this aberrant pattern of medical education, especially in the Mexican schools and in the group of entrepreneurial programs recently established on several West Indian islands, is extraordinarily high (29). Dubé, in her detailed analysis of the characteristics of students who applied to the COTRANS program in 1972-77, found that a high proportion of American students attracted to these schools come from families in the higher economic brackets and that their parents are more likely to be physicians or in other professional and managerial occupations (33).

Understandably, foreign medical schools are not eligible for direct Federal financial support. However, as revealed by the recently released report of the General Accounting Office study of six foreign medical schools attended by U.S. citizens, two Federal agencies, namely the Office of Education of the Department of Health, Education, and Welfare, now the Department of Education, and the Veterans Administration have been providing substantial financial subsidies to U.S. nationals studying medicine abroad. During the past ten years, the Office of Education granted about 21,500 loans for a total amount of over $45 million to such students; during fiscal 1979, the Department of Education guaranteed about 2,600 similar loans for $6 million. During the same ten year period the VA disbursed about $5.6 million in educational assistance grants to 997 veterans, their spouses and dependents so that they could attend foreign medical schools; during FY 1979, VA disbursements for this purpose amounted to about $300,000 in educational benefits to 150 eligible persons. The GAO report identified serious flaws in both the criteria and procedures used by these two agencies in determining eligibility and awarding these loans or educational grants (10).

The possibility exists that the availability of these sources of augmented financial support encouraged a larger number of students to attend some of the newer schools whose charges, it has been reported, are based less on educational costs than on what their organizers anticipate the market will bear (39-40). Whether the provisions in PL 94-484, modified somewhat by PL 95-215 (enacted on December 17, 1977) calling on U.S. medical schools to accept as transferees Americans studying medicine abroad, has served as an educational stimulus to Americans to seek medical educational opportunities abroad, is open to speculation.

From the above discussion, it should be reasonably apparent that, to date, not much success has been achieved in dissuading large numbers of candidates who have not gained admission to domestic medical schools from seeking some form of comparable training experience abroad. When U.S. medical schools were increasing in number and also expanding their enrollment, high hopes were expressed that this problem might, with time, solve itself. Such an expectation appears to be even more remote today than it did when the CCME Policy Statement was under consideration some five or six years ago. The Congress, the Executive Branch of the Federal Government and many qualified observers representing the private sector are now anticipating an excess in the production of physicians from domestic sources in the near future. If such predictions are correct, and there are sound reasons for concluding that they will be, it is essential that newer and more effective approaches be sought to the resolution of this highly complex issue. In both the short and long run, it may prove far easier to establish insurmount-

TABLE 12

PERFORMANCE ON 1980 ECFMG EXAMINATIONS OF U.S. NATIONALS ATTENDING FOREIGN MEDICAL SCHOOLS, ACCORDING TO REGIONAL AND COUNTRY LOCATION OF MEDICAL SCHOOL ATTENDED

Region and Country	*Examined Both Parts*	*Passed Both Parts*	*Passed M. but Failed E.*
Africa			
Egypt, A.R. (3)*	5	—	1
Nigeria (1)	1	1	—
Subtotal (3)	6	1	1
Asia			
Burma (1)	2	—	—
China (1)	2	1	—
China (Taiwan) (2)	10	2	—
India (7)	9	6	—
Iran (1)	2	—	—
Iraq (1)	1	1	—
Israel (2)	43	42	—
Korea R. (4)	10	2	2
Philippines (10)	142	65	1
Subtotals (29)	221	119	3
Central America & West Indies			
Costa Rica (1)	5	1	—
Cuba (1)	6	—	—
Dominica (1)	32	10	—
Dominican R. (7)	962	239	18
El Salvador (1)	2	—	--
Grenada (1)	122	101	—
Guatemala (1)	21	7	1
Haiti (1)	3	—	—
Honduras (1)	2	1	—
Jamaica (1)	7	2	1
Mexico (29)	1722	718	10
Montserrat (1)	48	30	—
Nicaragua (1)	1	—	—
Panama (1)	3	1	1
Subtotal (48)	2936	1110	31
Oceania			
Australia (3)	3	3	—
Iceland (1)	2	2	—
Subtotal (4)	5	5	—
Europe			
Austria (2)	22	9	—
Belgium (6)	34	28	—
Czechoslovakia (1)	2	—	—
Finland (1)	1	1	—
France (22)	38	25	—
German F.R. (14)	40	15	—
Greece (2)	49	17	—
Hungary (1)	14	3	—
Ireland (5)	14	13	—
Italy (17)	202	104	—
Netherlands (3)	4	2	—
Poland (6)	49	23	—
Portugal (2)	3	2	—
Rumania (3)	24	3	—
Spain (20)	344	45	12
Sweden (1)	1	1	—
Switzerland (5)	10	6	—
Turkey (2)	2	—	—
U.S.S.R. (1)	2	—	—
United Kingdom (3)	4	4	—
Yugoslavia (3)	4	1	—
Subtotals (120)	863	302	12
South America			
Argentina (4)	11	5	—
Bolivia (1)	1	1	—
Brazil (4)	5	2	—
Chile (1)	1	1	—
Colombia (5)	9	2	—
Ecuador (2)	5	1	—
Peru (1)	1	—	—
Venezuela (2)	6	1	—
Subtotal (20)	39	13	—
Totals			
Countries Represented		56	
Medical Schools Represented		224	
U.S. National Candidates Examined (in both Medicine and English)		4070	
Candidates Passing Both Parts		1550 (38.08)	
Candidates Failing Medicine		2473 (60.8)	
Candidates Passing Medicine But Failing English		47 (1.1)	

*( ) Number of Medical Schools Represented.

Source: Results of 1980 ECFMG Examinations, ECFMG, Philadelphia, 1981.

T.D.D./Jan. '81.

able barriers to alien physicians seeking to enter the practice of medicine in the U.S. than to deny to U.S. citizens the privilege of seeking a medical education at a place and institution of his own choosing as well as the right to compete with his peers for admission to medical practice in his own country. Whether the specific recommendations bearing on this issue recently offered by the Graduate Medical

Education National Advisory Committee will prove effective deterrants to the flow of Americans to foreign medical schools cannot readily be determined. However, these and possibly other recommendations warrant early and thoughtful consideration.

SUMMARY

WITHOUT QUESTION, the role of foreign medical graduates in the provision of medical care within the United States is in transition. The remarkable changes now in progress have frequently been linked with the approval by the Coordinating Council on Medical Education, in 1974, of the working document: Physician Manpower and Distribution: The Role of the Foreign Medical Graduate, and its formal endorsement by the Council's five parent organizations. That statement reflected the then mounting apprehension within the medical profession that this country had become overly dependent upon foreign medical schools as a major source of the physician manpower required to meet the increasing domestic demands for medical services, especially those provided by hospitals. An accompanying concern, also widely expressed, cautioned that for some foreign medical graduates, and perhaps in a significant number of instances, the type and even the quality of medical school preparation acquired in so many disparate educational institutions and cultures around the world were incompatible with the high standards of competence and performance demanded of graduates of domestic schools. The prevailing procedures employed in the screening of FMGs seeking to enter the U.S. were not sufficiently rigorous to assure the exclusion of those who, while receiving clinical training in hospital programs of graduate medical education, might jeopardize the health and safety of patients for whom they provided medical care. A series of recommendations were set forth in the policy statement calling for implementation through the voluntary and cooperative efforts of the parent professional associations and their affiliated organizations and institutions throughout the country.

A retrospective examination of data that have become available only within the past several years indicate that as early as 1974, or even perhaps in 1973 — definitely before the recommendations of the CCME policy statement were fully agreed upon — the flow of FMGs to the United States had already peaked, at least in terms of total numbers. That change in trend is now readily perceivable in multiple indicators including the number of candidates examined by the ECFMG, candidates receiving passing scores on the ECFMG examination and the number receiving ECFMG certification; the number of exchange visitor or other non-immigrant physicians admitted to the U.S. in any one year; the number of FMGs in accredited residency or other training positions; and the number of FMGs granted an initial license to practice medicine independently in a state or other jurisdiction. The specific factors contributing to these phenomena have not been clearly identified or fully validated. It is known, however, that some hospitals previously employing FMG interns or residents discontinued or curtailed this practice in favor of the recruitment of nurse practitioners or other categories of non-physician health care providers. The ECFMG adopted, in January 1974, a more stringent test of the comprehension of English as a spoken language as one of its prerequisites for ECFMG certification.

Concern lest the CCME recommendations be disregarded in a manner similar to the failure of implementation of the proposals made by the National Commission on Health Manpower, nine years earlier, was speedily dispelled by the enactment of PL 94-484 in October 1976. Title VI of that comprehensive health manpower legislation added highly restrictive amendments specific to foreign medical graduates to the provisions of the Immigration and Nationality Act. Declaring that "there is no longer an insufficient number of physicians and surgeons in the United States . . . ," Congress summarily terminated the highly permissive climate in which alien physicians could participate in American medical practice.

It was not the intent of the Congress to impose unwarranted and unreasonable restrictions to the flow of alien physicians who wished to come temporarily to the U.S. for clinical training in the specialties of medicine, training which otherwise would not be available to them. However, by mandating the exchange visitor program for physicians be restored to its original purpose, by placing inflexible limitations on physician migration to the U.S. and by requiring that all FMGs expecting "to perform services (in this country) as a member of the medical profession" meet standards of competence identical to those required of USMGs, the

Congress made clear its dissatisfaction with the status quo ante.

Some observers both within the U.S. and abroad were inclined to interpret the new legislation to read: "physicians trained elsewhere than in the U.S. and whose education and experience differ from that of their counterparts prepared for practice in U.S. medical schools, need not apply for an entrance visa to this country regardless of the purpose of such entry." For some the bright and shining image of the U.S. as the Mecca for specialized training in medicine had suddenly become dimmed and tarnished. However, alien physicians who can claim a family preference under the provisions of the Immigration and Nationality Act are completely exempt from the newly imposed restrictions on the immigration of physicians even though their lack of licensure or other professional qualifications bar them from the practice of medicine in any of the 54 separate licensing jurisdictions currently recognized within this country.

In the present report an effort has been made to summarize and to place in perspective such data as are now available reflecting the role foreign medical graduates are now playing in the provision of medical services to the American public. It may be paradoxical to observe — since the prime thrust of the provisions of Title VI of PL 94-484 was to stem the flow of physicians migrating permanently to the U.S. — that the most immediate and dramatic reduction in the number of FMGs coming to the U.S. since the enactment of that legislation has been among temporary visitors — those coming solely to benefit from a formal graduate medical education experience in a teaching hospital and who then are required to return to their country of previous domicile. In this area of international medical education we have already reverted to the level of activity that prevailed prior to the enactment of the Fulbright-Hays Act, the Mutual Educational and Cultural Exchange Act of 1961.

This may well be an appropriate level of such international educational activity for U.S. medical schools and their affiliated teaching hospitals. However, the decisions responsible for the current situation and for trends which may continue into the indefinite future, those embodied in Title VI of PL 94-484, were predicated upon a different set of premises — the threat of an impending glut in the number of physicians in practice within the U.S. A reasonably diligent search has failed to uncover any evidence indicating that the Congress even considered in passing what might be an appropriate level of graduate (or continuing) medical education that this country might offer to nationals of other countries as part of a planned program of international educational and cultural exchange for physicians and how best to underwrite the additional financial burdens that such activities impose upon the training institutions. There is evidence to suggest, that by limiting the length of specialty training now available to EVFMGs, an important group of teaching hospitals providing essential medical services to a disadvantaged segment of the American public have been seriously penalized and deprived of the services of some FMGs at a stage of their training when the services they render may heavily outweigh the dangers and disadvantages of an unduly protracted stay in this country.

Information available at this time does not permit the confident prediction of the ultimate effect that Title VI of PL 94-484 will have on the number of FMGs migrating permanently to the U.S. In view of the heightened barriers to such migration and the depletion of the backlog of FMGs exempted from the prohibition on visa adjustment from temporary visitor to permanent resident, it is reasonable to expect that in the longer range the number of FMGs who will gain permanent resident status and licensure to practice will decline even more precipitously than has already been noted for exchange visitor FMGs. In FY 1979, the most recent year for which INS data are now available, the number of new permanent resident visas issued to physicians receded to about 3,000, the lowest figure since 1969.

Of continuing concern to some observers is the fact that no substantial evidence can be found that since the issuance of the CCME policy statement a concerted national effort has been made to mobilize the extensive graduate medical educational resources available in this country to address the special and individualized needs of FMGs or to compensate for the recognizable deficiencies in their prior preparatory education with particular reference to the technological as well as the cultural requirements unique to the provision of medical care within an American setting. Such needs present a challenge of very sizeable proportions especially when appropriate attention is directed to the educational deficiencies of those FMGs who have acquired permanent resident status within the U.S., based on the close familial relationships recognized in the Immigration and Nationality Act,

and, accordingly, are exempt from all of the assurances of professional competence required of other physicians applying for either a temporary or a permanent entry visa.

These and similar issues referred to in the preceding sections of this report show little likelihood of disappearing of their own accord. Nor, are they being resolved either as a consequence of legislative mandates set down in Title VI of PL 94-484 or, alternatively, by the concerted action taken voluntarily within the private sector. These amendments have also brought into sharper focus pre-existing defects in our somewhat egotistically oriented system which has offered both graduate and continuing medical education opportunities in essentially cafeteria style to practically any alien physician who could gain admission to the U.S. regardless of the source of his medical degree and without reference to where or how the knowledge, skills and attitudes newly acquired in the U.S. would be utilized.

Moreover, few if any of these continuing problems and issues appear to be amenable to simple solutions or to alterations in educational practices left entirely to the discretion of individual directors of programs of graduate medical education or to the election of managers of teaching hospitals in which such programs are conducted. All of these complex issues warrant thoughtful reflection at the national level, the reconsideration of basic policy issues affecting all aspects of medical education — undergraduate, graduate and continuing — and the concerted and sustained action of multiple organizations and agencies.

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